DOCKET

SUPREME COURT
OF THE UNITED STATES

No. 11-1231
Title: Kathleen Sebelius, Secretary of Health and Human Services, Petitioner
v.
Auburn Regional Medical Center, et al.
Docketed: April 13, 2012
Linked with 11A864
Lower Ct: United States Court of Appeals for the District of Columbia Circuit
Case Nos.: (10-5115)
Decision Date: June 24, 2011
Rehearing Denied: December 20, 2011
Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Mar 9 2012	Application (11A864) to extend the time to file a petition for a writ of certiorari from March 19, 2012 to April 18, 2012, submitted to The Chief Justice.
Mar 13 2012	Application (11A864) granted by The Chief Justice extending the time to file until April 13, 2012.
Apr 13 2012	Petition for a writ of certiorari filed. (Response due May 14, 2012)
May 14 2012	Brief of respondent Auburn Regional Medical Center, et al. in opposition filed.
May 29 2012	DISTRIBUTED for Conference of June 14, 2012.
May 30 2012	Reply of petitioner Kathleen Sebelius, Secretary of Health and Human Services filed. (Distributed)
Jun 18 2012	DISTRIBUTED for Conference of June 21, 2012.
Jun 25 2012	Petition GRANTED.
Jul 23 2012	John F. Manning, Esquire, of Cambridge, Massachusetts, is invited to brief and argue this case, as amicus curiae, in support of the position that the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U. S. C. 1395oo(a)(3), may not be extended for any period.
Aug 3 2012	The brief of the Court-appointed amicus curiae is to be filed on or before August 31, 2012.
Aug 3 2012	The time to file the joint appendix and petitioner's brief on the merits is extended to and including September 11, 2012.
Aug 3 2012	The time to file respondents' brief on the merits is extended to and including October 16, 2012.
Aug 31 2012	Brief of Court-Appointed amicus curiae filed.
Sep 11 2012	Joint appendix filed.

Sep 11 2012	Brief of petitioner Kathleen Sebelius, Secretary of Health and Human Services filed.
Sep 14 2012	SET FOR ARGUMENT ON Tuesday, December 4, 2012.
Sep 14 2012	Brief amicus curiae of Professor Scott Dodson in support of neither party filed.
Oct 3 2012	Record received from U.S.C.A. for District f Columbia Circuit. (1 box)
Oct 5 2012	Record from U.S.D.C. for the District of Columbia is electronic.
Oct 16 2012	Brief of respondents Auburn Regional Medical Center, et al. filed. (Distributed)
Oct 17 2012	CIRCULATED.
Oct 19 2012	Brief amicus curiae of Benjamin N. Cardozo School of Law Tax Clinic filed. (Distributed)
Oct 23 2012	Brief amicus curiae of American Hospital Association filed. (Distributed)
Oct 23 2012	Brief amicus curiae of Southwest Consulting Associates, LP filed. (Distributed)
Oct 23 2012	Brief amicus curiae of Quality Reimbursement Services, Inc. filed. (Distributed)
Oct 23 2012	Motion of Court-Appointed amicus curiae for divided argument filed.
Nov 13 2012	Motion of Court-Appointed amicus curiae for divided argument GRANTED.
Nov 15 2012	Reply of petitioner Kathleen Sebelius, Secretary of Health and Human Services filed. (Distributed)
Nov 15 2012	Reply of Court-Appointed amicus curiae filed. (Distributed)
Dec 4 2012	Argued. For petitioner: Edwin S. Kneedler, Deputy Solicitor General, Department of Justice, Washington, D. C. For Court-Appointed amicus curiae: John F. Manning, Cambridge, Mass. (Appointed by this Court.) For respondent: Robert L. Roth, Washington, D. C.

PETITION FOR WRIT OF CERTIORARI

No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. 1395*oo*(a)(3), is subject to equitable tolling.

PARTIES TO THE PROCEEDING

Petitioner is Kathleen Sebelius, Secretary, United States Department of Health and Human Services.

Respondents are Auburn Regional Medical Center, Chalmette Regional Medical Center, Doctors Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, McAllen Medical Center, Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital, UHS of New Orleans, Universal Health Services, Inc., Valley Hospital Medical Center, and Wellington Regional Medical Center.

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No. 11-1231

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

The Solicitor General, on behalf of Kathleen Sebelius, Secretary of Health and Human Services, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-10a) is reported at 642 F.3d 1145. The amended opinion of the district court (App., *infra*, 11a-50a) is reported at 686 F. Supp. 2d 55. The decision of the Provider Reimbursement Review Board (App., *infra*, 51a-56a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 24, 2011. Petitions for rehearing were denied on December 20, 2011 (App., *infra*, 61a-66a). On March 13, 2012, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including April 13, 2012. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions are reproduced in the appendix to this petition. App., *infra*, 67a-83a.

STATEMENT

1. The Medicare program, established by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* (Medicare statute), pays for certain medical services provided to elderly and disabled patients entitled to benefits under the program. Under the Prospective Payment System (PPS) for reimbursement of providers under Part A of Medicare, hospitals providing inpatient Medicare services are paid prospectively at a fixed amount for each patient discharged, regardless of actual costs incurred. 42 U.S.C. 1395ww(d) (2006 & Supp. IV 2010). Hospitals submit cost reports at the end of each fiscal year to contractors, known during the relevant time period as fiscal intermediaries, which are generally private insurance companies acting on behalf of the Department of Health and Human Services (HHS). See 42 C.F.R. 405.1801(b)(1), 413.24(f) (2011). The intermediary determines the total payment (including any hospital-specific adjustments) and issues a Notice of

Program Reimbursement (NPR), informing the provider how much it will be paid for the fiscal year at issue. 42 C.F.R. 405.1803 (2011).

If a provider is dissatisfied with its NPR and meets the amount-in-controversy requirement, it may appeal to the Provider Reimbursement Review Board (PRRB or Board) "if * * * [it] files a request for a hearing within 180 days after notice of the intermediary's final determination." 42 U.S.C. 1395*oo*(a)(3). The Board is composed of five members "knowledgeable in the field of payment of providers of services" and appointed by the Secretary of Health and Human Services (Secretary), 42 U.S.C. 1395*oo*(a) and (h), and it has the authority to affirm, modify, or reverse the final determination of the intermediary, 42 U.S.C. 1395*oo*(d). The decision of the Board is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. 42 U.S.C. 1395*oo*(f)(1).[1] A provider may seek judicial review of "any final decision of the Board" by filing suit in federal district court within 60 days. *Ibid.*

HHS regulations provide the Board with limited discretion to extend the time limit for filing an appeal of the intermediary's final determination, but only in circumscribed instances in which "good cause [is] shown," and the request is filed within three years after issuance of the NPR. 42 C.F.R. 405.1841(b) (2007).[2] Specifically,

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[1] The Secretary's review authority has been delegated to the Administrator of the Centers for Medicare & Medicaid Services (CMS), 49 Fed. Reg. 35,248 (Sept. 6, 1984), and may be redelegated to the Deputy Administrator of CMS, *id.* at 35,251.

[2] Unless otherwise indicated, all references to Title 42, C.F.R., are to the 2007 version. Subsequent amendments apply only to administrative "appeals pending as of, or filed on or after, August 21, 2008," see 73

during the relevant time period, HHS regulations provided that "[a] request for a Board hearing filed after the [180-day time limit] shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider." *Ibid.*[3]

Apart from the administrative appeal process, a provider may also obtain administrative relief from an intermediary's final reimbursement determination by requesting that the intermediary "reopen" its determination. See 42 C.F.R. 405.1885(a). Such a request, however, "must be made within 3 years of the date of the notice of the intermediary" determination, and "[n]o such determination * * * may be reopened after such

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Fed. Reg. 30,190 (May 23, 2008), and, accordingly, do not directly apply to this case. See App., *infra*, 15a n.3.

[3] The "good cause" regulation was subsequently amended and is now codified at 42 C.F.R. 405.1836 (2011). As amended, "[t]he Board may find good cause * * * only if the provider demonstrates * * * [that] it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike)." 42 C.F.R. 405.1836(b) (2011). The request must be "received by the Board within a reasonable time" after "expiration" of the 180-day limit, and the Board may not grant an extension request if received "later than 3 years after" the NPR. 42 C.F.R. 405.1836(b) and (c)(2) (2011). The Board is also prohibited from granting an extension for good cause if "[t]he provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request." 42 C.F.R. 405.1836(c)(1) (2011). A finding "that the provider did or did not demonstrate good cause * * * is not subject to judicial review." 42 C.F.R. 405.1836(e)(4) (2011).

3-year period" absent a specified exception. *Ibid.*[4] An intermediary's denial of a provider's reopening request is not subject to administrative review by the PRRB or to judicial review. See *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 452-457 (1999) (*Your Home*).

2. This case arises against the background of litigation brought by Baystate Medical Center (Baystate), which is not a party to this action. See *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, amended in part, 587 F. Supp. 2d 37 (D.D.C. 2008) (*Baystate*). Like *Baystate*, this case involves an adjustment to the Medicare payment that is available to hospitals "serv[ing] a significantly disproportionate number of low-income patients," referred to as a "disproportionate share hospital" or "DSH" adjustment. 42 U.S.C. 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the Medicare DSH adjustment and the amounts of any adjustment depend on the hospital's "disproportionate patient percentage." 42 U.S.C. 1395ww(d)(5)(F)(v). As defined by statute, the "disproportionate patient percentage" consists of two components, commonly known as the "Medicare/SSI fraction" and the "Medicaid fraction." See 42 U.S.C. 1395ww(d)(5)(F)(vi). The numerator of the Medicare/SSI fraction, which is at issue here, "is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under [Medicare Part A]" and who were also entitled to Supplemental Security Income (SSI) benefits; the denominator consists of the number

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[4] One exception requires the reopening of an intermediary's determination beyond the three-year period "if it is established that such determination * * * was procured by fraud or similar fault of any party to the determination." 42 C.F.R. 405.1885(d).

of patient days which were made up of patients who (for such days) were entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I); cf. 42 U.S.C. 1381 *et seq.* (establishing national program to provide SSI benefits to aged, blind, or disabled individuals whose income falls below a certain level); *Sullivan* v. *Zebley*, 493 U.S. 521, 524 (1990). The Centers for Medicare & Medicaid Services (CMS) determines the Medicare/SSI fraction for each hospital and provides that information to the responsible intermediary. 42 C.F.R. 412.106(b). The intermediary then determines the total payment amount a hospital is due (including any DSH adjustment) and issues an NPR.

Each of the respondent hospitals received an NPR, which included its DSH adjustment determination, for fiscal years 1987 through 1994. Respondents did not appeal those determinations to the Board within 180 days as required by statute. See 42 U.S.C. 1395*oo*(a)(3); App., *infra*, 17a. Nor did they seek discretionary relief from the 180-day deadline within three years for "good cause shown," 42 C.F.R. 405.1841(b), or request "reopening" by the intermediary within three years, 42 C.F.R. 405.1885(a). See App., *infra*, 18a, 29a & n.9, 45a, 52a, 55a. By contrast, Baystate did timely appeal its DSH adjustment determinations for fiscal years 1993 through 1996, and the Board found that certain errors in CMS' calculation of the Medicare/SSI fraction "tended to deflate the overall DSH payment." *Id.* at 17a-18a.

In September 2006, several months after the Board's *Baystate* decision and more than a decade after the statutory appeal deadlines had expired, respondents attempted to appeal the intermediaries' determinations of their DSH adjustments for fiscal years 1987 through 1994, to the Board. App., *infra*, 2a, 18a. Respondents

acknowledged that their appeals to the Board were untimely, but urged that equitable tolling is appropriate "because the hospitals' failure to file an appeal within 180 days of issuance of the NPRs was the result of CMS's refusal to inform the hospitals that their SSI percentages were incorrectly understated for the fiscal years at issue." *Id.* at 18a-19a. In respondents' view, "the appeals were timely [under an equitable tolling theory] because they were filed within 180 days of the Board's *Baystate* decision." *Id.* at 19a.

The Board dismissed respondents' appeals, concluding that it lacked authority to decide them. Relying in part on its earlier decision in *Anaheim Memorial Hospital* v. *Blue Cross & Blue Shield Ass'n*, Nos. 93-1920 and 94-0007, 2000 WL 1146514 (July 3, 2000), the Board held that it could not grant "equitable relief" such as "equitable tolling." App., *infra*, 55a. The Board explained that it "is an administrative forum and, unlike the courts, [it] does not have general equitable powers but rather only the powers granted to it by statute and regulation." *Ibid.* The Secretary declined to review the Board's decision. *Id.* at 57a-60a.

3. Respondents then filed this action in the District Court for the District of Columbia arguing, among other things, that the Board should have equitably tolled the 180-day time limit. The district court granted the government's motion to dismiss. App., *infra*, 11a-50a.

As relevant here, the district court held that the Medicare statute does not authorize equitable tolling of the 180-day administrative appeal period. The court explained that the presumption in favor of equitable tolling recognized in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), does not apply to the Medicare limitations period because no sufficiently

"similar" private suit had been identified and "the programmatic reimbursement at issue is not familiar to private litigation." App., *infra*, 32a. "Based on the statutory language, the regulations granting only limited exceptions to the 180-day limitations period, and the Supreme Court's determination in *Your Home* that the 180-day limit may not be circumvented by expanding Board (and hence, district court) jurisdiction to review requests to reopen," the court concluded that "equitable tolling of the 180-day limitations period is not available under 42 U.S.C. § 1395*oo*." *Id.* at 38a-39a. That conclusion, the court explained, was "buttressed by the scope and complexity of the Medicare program." *Id.* at 40a.

4. The court of appeals reversed. App., *infra*, 1a-10a. Concluding that the 180-day period for requesting a hearing is subject to equitable tolling, the court of appeals remanded to the district court for "further factual development" to determine whether tolling is "appropriate" in this case. *Id.* at 10a.[5]

The court of appeals applied a presumption in favor of equitable tolling based, in part, on its conclusion that a claim for Medicare payment is "'familiar to private litigation' because it is analogous to a contract claim." App., *infra*, 5a-6a & n.1. The court then concluded that the presumption had not been rebutted because, in the court's view, the statutory language imposing the time limit for appeal of Medicare payment determinations is "fairly simple," there are no statutory exceptions, and the timing provision is not itself complex. *Id.* at 9a-10a. The court recognized that there is a "good cause" excep-

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[5] Although the court of appeals remanded to the district court, we assume (consistent with ordinary principles of administrative law) that the court intended the district court to first remand to the Board for any "further factual development."

tion provided under the Secretary's regulations, but it concluded that such regulatory exceptions are immaterial to the equitable tolling inquiry and, in any event, not sufficiently technical to rebut the presumption. *Id.* at 9a. The court also concluded that, although the Medicare statute "is quite complex," it is nevertheless "amenable to tolling" because "its timing scheme is straightforward." *Id.* at 10a.

REASONS FOR GRANTING THE PETITION

The court of appeals has held that the 180-day statutory time limit for a provider to file an administrative appeal with the PRRB from a final payment determination by a fiscal intermediary is subject to equitable tolling. That decision is wrong; it is unprecedented in the nearly 40-year existence of the Board; it cannot be reconciled with decisions of other courts of appeals; and it is in considerable tension with this Court's decision in *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449 (1999). If allowed to stand, the decision would impose a substantial administrative and financial burden on the Medicare program.

At the outset, the presumption in favor of judicially fashioned principles of equitable tolling of limitations periods for filing a suit in court is inapplicable in the quite distinct context of administrative proceedings for adjudicating claims before a tribunal like the PRRB. The exceedingly complex substantive and procedural framework for resolving Medicare payment claims through an administrative process has no analogue in the filing of a private suit in court, and it is not traditionally governed by general equitable principles that go beyond the specific terms and limitations in the Medicare statute and implementing regulations. Moreover,

the mandatory administrative appeal process was enacted by Congress long before this Court applied any presumption in favor of the availability of equitable tolling even in suits against the United States in court.

Assuming arguendo, however, that a presumption in favor of equitable tolling not provided for by statute or regulation is appropriate, any such presumption is rebutted here. Congress affords Medicare providers a right to appeal the intermediary's final determination to the PRRB, but only "if," among other things, the appeal is filed within 180 days of issuance of the NPR. The statutory language on its face provides no basis for judicially fashioned exceptions. "[T]he tens of thousands of sophisticated Medicare-provider recipients of these NPRs [are] generally capable of identifying an underpayment in [their] own NPR[s] within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Your Home*, 525 U.S. at 455-456. And the Secretary, who is charged with administering the Medicare program has, as a matter of "grace," *id.* at 454, prescribed only two circumscribed exceptions to that limitation—neither of which is applicable here. See 42 C.F.R. 405.1841(b), 405.1885(a). The court of appeals' imposition of an open-ended equitable tolling regime on top of this carefully crafted procedural framework established by the Medicare statute and regulations is contrary to basic principles of judicial review of agency action under this Court's decision in *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978) (*Vermont Yankee*).

The court of appeals' decision also cannot be reconciled with decisions in the Eighth and Eleventh Circuits, and with this Court's understanding of the Medicare reimbursement regime in *Your Home*. If allowed to stand, the decision would impose a considerable adminis-

trative burden on HHS and would expose the Medicare Trust Fund to substantial and unpredictable liabilities for past cost years that have long since been closed.

Because all Medicare providers may seek judicial review of any final decision of the Board in the District Court for the District of Columbia, the D.C. Circuit's decision in this case, unless reversed by this Court, can be expected to have a broad effect on the nationwide administration of the Medicare program going forward. Review by this Court is warranted.

A. The 180-Day Administrative Appeal Period Is Not Subject To Equitable Tolling

The court of appeals erred by holding that the Medicare statute requires the 180-day period for requesting an administrative appeal to be subject to general principles of equitable tolling, even where the Secretary has not so provided. That holding cannot be squared with this Court's decisions concerning judicial review of agency action, with the factors for determining when equitable tolling is available, with the Medicare provider payment scheme, or with the considered judgment of the expert agency charged with administering the Medicare program.

1. In *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990), this Court held that "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States." *Id.* at 95-96. The court of appeals held that such a presumption is applicable to the time limit in 42 U.S.C. 1395*oo*(a)(3) because a provider's Medicare claim for additional payment is "analogous to a contract claim." App., *infra*, 6a n.1. That conclusion is fundamentally mistaken.

a. As an initial matter, the presumption in favor of judicially fashioned principles of equitable tolling of limitations periods for filing a suit in court is inapplicable in the quite distinct context of a statutory and regulatory framework for adjudicating claims before an administrative tribunal such as the PRRB. When a statutory provision like 42 U.S.C. 1395*oo*(a)(3) speaks to substantive or procedural matters to be resolved by an administrative agency, the interpretation and implementation of that provision are presumptively entrusted to that agency in the first instance, not to the courts. Here, the statutory and regulatory review scheme limits the Board's authority to hear appeals from final determinations of the fiscal intermediary to those appeals filed within 180 days of the NPR, or three years from that date if the provider is able to demonstrate "good cause." See 42 U.S.C. 1395*oo*(a)(3); 42 C.F.R. 405.1841(b); App., *infra*, 55a-56a. That carefully calibrated administrative appeal process should not be set aside (or modified by court-imposed equitable principles) unless a court concludes that the limits imposed by the Secretary on any extension of the 180-day deadline are arbitrary and capricious. See *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 418-419 (1993). There is no basis for any such conclusion.

The Medicare statute confers broad authority on the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs" under the statute. 42 U.S.C. 1395hh(a)(1); accord 42 U.S.C. 405(a), 1302(a). The Secretary's rulemaking authority encompasses the authority to prescribe regulations governing the timeliness of provider appeals to the Board. See 73 Fed. Reg. 30,206 (May 23, 2008); cf. *Weinberger* v. *Salfi*, 422 U.S. 749, 766 (1975)

(noting Secretary's rulemaking authority to define agency's "final decision" triggering right of judicial review under 42 U.S.C. 405(g)).[6]

In 1974 and 2008, the Secretary engaged in notice-and-comment rulemaking implementing the statutory administrative review provisions, including the 180-day appeal deadline. See 39 Fed. Reg. 34,517 (Sept. 26, 1974); 73 Fed. Reg. at 30,191 (discussing history of regulations). As the Secretary explained in the preamble to the 2008 revisions to the "good cause" regulation, the agency's "longstanding policy has permitted extensions of the timeframe for requesting hearings only in limited circumstances." *Id.* at 30,206.[7] Through those regulations, the Secretary has consistently prohibited the Board from entertaining an untimely appeal *unless* (1) the provider demonstrates "good cause," and (2) the request is made no more than three years after the NPR. See 39 Fed. Reg. at 34,517. The limitation on that narrow exception to the 180-day appeal period is emphatic:

> A request for a Board hearing filed after the [180-day time limit] *shall* be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, *no such extension shall be*

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[6] Although Congress has amended 42 U.S.C. 1395*oo* several times since 1974, see, *e.g.*, Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, Tit. IX, § 955, 94 Stat. 2647, it has never altered the 180-day administrative appeal period or the Secretary's rulemaking authority, nor has it overridden the Secretary's three-year outer time limit on the "good cause" exception.

[7] The amendments to the regulations, see notes 2-3, *supra*, were designed to "lead to a more effective and efficient appeal process," and to reduce the "huge backlog of cases before the Board." 73 Fed. Reg. at 30,192.

> *granted* by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

42 C.F.R. 405.1841(b) (emphases added); cf. *Kontrick* v. *Ryan*, 540 U.S. 443, 458 (2004) (relevant question for nonjurisdictional time limit in procedural rule is "whether the time restrictions in th[e] Rules are in such emphatic form as to preclude equitable exceptions") (internal quotation marks omitted; brackets in original).

In *Your Home*, this Court recognized that "[t]he right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180-day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395*oo*(a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely." 525 U.S. at 454. The same is true of the regulatory "good cause" exception to the 180-day deadline for administrative appeals. That exception exists solely "by grace of the Secretary," and the Secretary reasonably concluded that allowing administrative appeals to be filed in an open-ended manner, more than three years after issuance of an NPR, would frustrate "the statutory purpose of imposing a 180-day limit on the right to seek Board review." *Ibid.*

The "good cause" regulation reflects the Secretary's "belie[f that] it is fair and appropriate that, absent extraordinary circumstances, providers should be expected to file their appeals within the 180-day period," and should not be permitted to "depend on a right to file late if there is a favorable change in the law at some point after the 180-day appeal period." 73 Fed. Reg. at 30,206. The Secretary has broad authority to administer the Medicare program. Her considered judgment as to

whether and when the 180-day administrative appeal deadline should be extended, which was rendered through notice-and-comment rulemaking, is entitled to substantial deference. See *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 21 (2000); see also *Good Samaritan Hosp.*, 508 U.S. at 417-418 (noting that the Court "should be especially reluctant to reject the agency's" interpretation when it "so closely fits the design of the statute as a whole," as well as "its object and policy") (internal quotation marks and citations omitted); *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1235 (D.C. Cir. 1994) (upholding as reasonable Secretary's decision "that the interests in finality and administrative efficiency outweighed the value of increased accuracy"). By engrafting a judge-made equitable tolling requirement onto the 180-day administrative appeal period, the court of appeals has effectively created a "good cause" exception of its own without any temporal limit and governed by judicially fashioned equitable tolling principles, rather than the standards in the Secretary's "good cause" regulation. The court of appeals' decision thus is contrary to "the very basic tenet of administrative law that agencies should be free to fashion their own rules of procedure." *Vermont Yankee*, 435 U.S. at 543-544.[8]

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[8] In *Zipes* v. *TWA, Inc.*, 455 U.S. 385 (1982), the Court concluded that the statutory time limit for filing charges with the Equal Employment Opportunity Commission (EEOC) under Title VII of the Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 253, was not a "jurisdictional prerequisite to suit" in district court, but rather was subject to equitable doctrines such as waiver, estoppel, and tolling. 455 U.S. at 393. The Court found that such equitable principles were consistent with the statutory scheme, wherein "laymen, unassisted by trained lawyers, initiate the process." *Id.* at 397. The EEOC (and the United States) argued in favor of equitable modification of the charge-filing period, and did not suggest that the EEOC lacked authority to apply

b. Even if the factors considered by the Court in cases concerning equitable tolling of limitations periods for judicial actions did have some application here, a presumption in favor of equitable tolling would be inappropriate.

Although a "precise private analogue" is not required in order to invoke the *Irwin* presumption, *Scarborough* v. *Principi*, 541 U.S. 401, 422 (2004), the court of appeals erred in holding that a Medicare provider's administrative appeal seeking payment is sufficiently analogous to a private contract action to trigger a presumption in favor of equitable tolling. Medicare provider payments depend on the statute and regulations, not on independent contractual terms. Respondents' claim that the Secretary should recalculate their Medicare payments under complex statutory and administrative standards is "so peculiarly governmental that there is no basis for assuming [that the] customary ground rules apply." *Chung* v. *United States Dep't of Justice*, 333 F.3d 273, 277 (D.C. Cir. 2003).

But even if respondents' Medicare reimbursement claims were deemed similar in some respects to a private suit in court for breach of contract, any presumption in favor of equitable tolling would nonetheless be misplaced in this context. In *Holland* v. *Florida*, 130 S.

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equitable tolling. See Gov't Amici Br., *Zipes*, *supra* (Nos. 78-1545 and 80-951). By contrast, the considered judgment of the agency charged with administering the Medicare program is that judicially (or Board) fashioned equitable tolling is incompatible with the statutory and regulatory scheme. And, again in contrast to *Zipes*, the reimbursement system under the Medicare Part A program applies to sophisticated providers which *are* assisted by "trained lawyers," and thus presents no such justification for a court to impose a doctrine of equitable tolling on the program and the Board that decides administrative appeals under it.

Ct. 2549 (2010), which involved the statute of limitations for filing habeas corpus petitions, this Court explained that the presumption in favor of equitable tolling was "reinforced" and "strength[ened]" by two factors: (1) "the fact that equitable principles have traditionally governed the substantive law of habeas corpus," and (2) "the fact that Congress enacted [the Antiterrorism and Effective Death Penalty Act (AEDPA)] after the Court decided *Irwin* and therefore was likely aware that courts, when interpreting AEDPA's timing provisions, would apply the presumption." *Id.* at 2560-2561 (internal quotation marks and citations omitted). Similarly, in *Young* v. *United States*, 535 U.S. 43 (2002), which involved the "three-year lookback period" in the Bankruptcy Code, the Court noted that the *Irwin* presumption is appropriate "when [Congress] is enacting limitations periods to be applied by bankruptcy courts, which are courts of equity and apply the principles and rules of equity jurisprudence." *Id.* at 50 (internal quotation marks and citations omitted; brackets omitted).

Neither factor is present here. Unlike habeas corpus and bankruptcy litigation, and the Title VII discrimination claim presented in *Irwin*, general "equitable principles," unrooted in statutory or regulatory text, have not "traditionally governed" the "substantive law" of Medicare provider payment, let alone the administrative appeal process. Cf. *United States* v. *Brockamp*, 519 U.S. 347, 352 (1997) (noting that tax law "is not normally characterized by case-specific exceptions reflecting individualized equities"). The Board has thus concluded that it has no residual equitable powers with respect to the 180-day deadline unless provided by the Medicare statute or an implementing regulation. See App., *infra*, 55a-56a; *Anaheim Mem'l Hosp.* v. *Blue Cross & Blue*

Shield Ass'n, No. 93-1920 and 94-0007, 2000 WL 1146514 (P.R.R.B. July 3, 2000) (*Anaheim*). And the 180-day administrative appeal period was first enacted in 1972, Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1420—many years before this Court decided *Irwin*. Accordingly, Congress plainly was not "aware that courts, when interpreting" even federal statutes governing the filing of a suit against the United States in court, much less the Medicare statute's administrative-appeal "timing provisions, would apply the presumption." *Holland*, 130 S. Ct. at 2561.[9]

2. Even if a presumption in favor of equitable tolling were to apply in some way in this very different context, the relevant inquiry under *Irwin* would be whether "there [is] good reason to believe that Congress did *not* want the equitable tolling doctrine to apply." *Brockamp*, 519 U.S. at 350. Here, there is more than ample reason.

a. Section 1395*oo*(a)(3) establishes an administrative appeal deadline in unambiguous terms. A provider may

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[9] The Court's decision in *Bowen* v. *City of New York*, 476 U.S. 467 (1986), is readily distinguishable. In that case, the Court allowed equitable tolling of the 60-day limitations period for seeking *judicial* review of the Secretary's Social Security benefits determination. *Id.* at 478-482; cf. *id.* at 482-486 (dispensing with exhaustion requirement for plaintiffs who failed to timely pursue claims before the agency). The Court did not apply any presumption in favor of equitable tolling, but rather focused on whether equitable tolling was "consistent with Congress' intent." *Id.* at 479-480. Because the benefits scheme was "designed to be 'unusually protective' of claimants," *id.* at 480, the Court concluded that equitable tolling was appropriate. The same plainly cannot be said of the 180-day *administrative* appeal period for "sophisticated" institutional providers, *Your Home*, 525 U.S. at 456, to seek Medicare reimbursement.

appeal an intermediary's reimbursement determination to the Board only

> if— * * * (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. 1395*oo*(a)(3);[10] see H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (1971) ("The appeal *must* be filed within 180 days after notice of the fiscal intermediary's final determination.") (emphasis added). The 180-day appeal period is reiterated three times in this provision, and the time deadline is just one of three mandatory preconditions to invoking administrative review. See 42 U.S.C. 1395*oo*(a). Neither of the other two preconditions—provider dissatisfaction and a $10,000 amount-in-controversy requirement—is readily amenable to equitable exceptions. See 42 U.S.C. 1395*oo*(a)(1) and (2); *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 404 (1988) ("[A] provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction."); cf. *Hallstrom* v. *Tillamook County*, 493 U.S.

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[10] Paragraph (1)(A)(i) applies to circumstances in which a provider is dissatisfied with a final determination of the intermediary; Paragraph (1)(A)(ii) applies to circumstances in which a provider is dissatisfied with a final determination of the Secretary under 42 U.S.C. 1395ww(b) or (d) (2006 & Supp. IV 2010); and Paragraph (1)(B) and (C) addresses circumstances in which a provider has not received a final determination from the intermediary on a timely basis after filing a compliant cost report, or supplemental cost report, respectively.

20, 31 (1989) (identifying "mandatory conditions precedent to commencing suit" that the "district court may not disregard * * * at its discretion").[11]

b. The court of appeals failed to appreciate the significance of the fact that Section 1395*oo*(a)(3) prescribes a time deadline for filing an administrative appeal with the PRRB, not a statute of limitations for filing suit in federal court. Unlike a court, the PRRB is "established by the Secretary" and is "composed of five members appointed by the Secretary," two of whom "shall be representative of providers of services," "at least one" of whom "shall be a certified public accountant," and all of whom must be "knowledgeable in the field of payment of providers of services." 42 U.S.C. 1395*oo*(a) and (h). Whereas the providers and the intermediary are parties to the proceedings before the Board, 42 C.F.R. 405.1843(a) (2011), HHS itself cannot be a party, 42 C.F.R. 405.1843(b) (2011). In short, the PRRB and its procedures were not established and are not suited for the adjudication of the sort of fact-specific equitable tolling claims that would now routinely be asserted as a result of the D.C. Circuit's decision.

c. Finally, and significantly, "the statute at issue * * * relate[s] to an 'underlying subject matter[]' * * * with respect to which the practical consequences of permitting tolling would [be] substantial." *Holland*, 130 S. Ct. at 2561. The court of appeals readily conceded that "the Medicare statute * * * is quite complex," App., *infra*, 10a, and "that the complex Medicare

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[11] The statutory time limit has substantive, as well as procedural, effects. See *Brockamp*, 519 U.S. at 352. Section 1395*oo*(f)(2) provides for the accrual of interest "beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section." 42 U.S.C. 1395*oo*(f)(2).

reimbursement scheme will be more difficult to administer with equitable tolling available to claimants," *id.* at 66a (Griffith and Williams, JJ., concurring in the denial of rehearing en banc). Yet the court of appeals rejected the Secretary's reliance on this Court's discussion of similar considerations in *United States* v. *Brockamp*, *supra*, which held that the time limit for seeking a tax refund under the Internal Revenue Code was not subject to equitable tolling. The court of appeals reasoned that *Brockamp* was focused not on "the complexity of tax law per se, but rather the complexity of the provisions governing whether and when a claim could be filed." App., *infra*, 9a. The court misread *Brockamp* and this Court's equitable tolling cases.

In *Brockamp*, the Court defined the "underlying subject matter" as "tax collection" and focused on the number of tax returns filed each year and the number of refunds issued. 519 U.S. at 352-353. In *United States* v. *Beggerly*, 524 U.S. 38 (1998), the Court held that the statutory time limit in the Quiet Title Act could not be equitably tolled because, among other things, "the underlying claim 'deal[t] with ownership of land' and thereby implicated landowners' need to 'know with certainty what their rights are, and the period during which those rights may be subject to challenge.'" *Holland*, 130 S. Ct. at 2561 (quoting *Beggerly*, 524 U.S. at 48-49). And, in *Holland*, the Court broadly described the relevant subject matter in *Brockamp* as "tax collection" and in *Beggerly* as "land claims." *Ibid.* As the Court emphasized in *Holland* in allowing equitable tolling under AEPDA, "unlike the subject matters at issue" in *Brockamp* and *Beggerly*, "AEDPA's subject matter, habeas corpus, pertains to an area of the law where equity finds a comfortable home." *Ibid.*; cf. *id.* at 2562

(considering whether equitable tolling would "undermine[]" statute's "basic purposes").

The Medicare statute is far more analogous to the subject matter in *Brockamp* (tax collection) and *Beggerly* (land claims), than to the subject matter in *Holland* (habeas corpus) or *Irwin* (Title VII). The Medicare system is one of the most detailed and complex federal administrative programs ever created. See *Illinois Council on Long Term Care*, 529 U.S. at 13; *Methodist Hosp.*, 38 F.3d at 1229. It is akin to tax collection in terms of its sheer size and complexity. Medicare contractors annually process claims for approximately 6000 hospitals, 15,000 skilled nursing facilities, and other providers of care under Medicare Part A, resulting in annual expenditures of approximately $250 billion. HHS, *2011 CMS Statistics*, Tbls. II.1, II.3, III.5, June 2011, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html (last visited Apr. 13, 2012) (*2011 Stats*); cf. *Brockamp*, 519 U.S. at 352 ("The IRS processes more than 200 million tax returns each year" and "issues more than 90 million refunds."). More than $139 billion in Medicare Part A benefit payments are made annually for inpatient hospital services alone. *2011 Stats*, Tbl. III.6.

As explained in detail below (see Part B.3, *infra*), an equitable tolling regime would place substantial additional burdens on the agency, on its contractors, and on the Medicare Trust Fund that Congress did not envision and could not have intended. Thus, just as "read[ing] an 'equitable tolling' exception into § 6511 [of the Internal Revenue Code] could create serious administrative problems by forcing the IRS to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for 'equitable tolling' which, upon close inspec-

tion, might turn out to lack sufficient equitable justification," *Brockamp*, 519 U.S. at 352, a requirement that equitable tolling be imposed on the Medicare program could create similar administrative problems for HHS. Just as in *Brockamp*, "Congress would likely have wanted to decide explicitly whether, or just where and when, to expand the statute's limitations period, rather than delegate to the courts a generalized power to do so wherever a court concludes that equity so requires," *id.* at 353—or to impose that task on a five-person administrative review body (the PRRB) created for its expertise in resolving technical hospital cost and reimbursement issues. In the end, the "nature and potential magnitude of the administrative problem suggest that Congress decided to pay the price of occasional unfairness in individual cases * * * in order to maintain a more workable" payment system. *Id.* at 352-353.

B. The Court Of Appeals' Decision Warrants This Court's Review

1. The court of appeals' decision cannot be reconciled with the Eleventh Circuit's decision in *Alacare Home Health Services, Inc.* v. *Sullivan*, 891 F.2d 850 (1990) (*Alacare Home Servs.*), or the Eighth Circuit's decision in *St. Joseph's Hospital* v. *Heckler*, 786 F.2d 848 (1986). In both cases, the courts of appeals concluded that the 180-day administrative appeal period set forth in 42 U.S.C. 1395*oo*(a)(3) is "jurisdictional" in nature and admits of no exceptions, and on that basis declared invalid the agency's regulation permitting extension of the 180-day period for "good cause." See *Alacare Home Servs.*, 891 F.2d at 855-856 (concluding that the Secretary was not authorized to create exceptions to the mandatory 180-day time limit); *St. Joseph's Hosp.*, 786 F.2d at 852-853 (concluding that "the 180 day time pe-

riod for filing claims with the Board is a jurisdictional prerequisite to the Board's authority to review a claim," and that the agency therefore lacked authority to extend the time limit). But see *Western Med. Enters., Inc.* v. *Heckler*, 783 F.2d 1376, 1379-1380 (9th Cir. 1986) (upholding "good cause" regulation). The issue presented in the Eighth and Eleventh Circuit cases was whether the agency properly concluded that the provider had failed to demonstrate "good cause" and, accordingly, neither court specifically considered the question of equitable tolling. Nevertheless, the courts' conclusion that the time limit is jurisdictional, and their rejection of even the Secretary's own "good cause" regulation allowing a limited extension, necessarily preclude recognition of an equitable tolling exception in those circuits. See *Bowles* v. *Russell*, 551 U.S. 205, 214 (2007) (court "has no authority to create equitable exceptions to jurisdictional requirements").

Thus, after the D.C. Circuit's decision, there are now three different (and irreconcilable) regimes governing the time limits on administrative appeals: (1) the 180-day statutory time limit is jurisdictional and administrative appeals filed after 180 days are categorically barred, regardless of the reason for the delay and the Secretary's "good cause" regulation (Eighth and Eleventh Circuits); (2) the 180-day statutory time limit governs unless the provider seeks an extension within three years and can demonstrate "good cause" as defined by regulation (HHS); and (3) the 180-day statutory time limit is subject to open-ended equitable tolling as defined by the courts (D.C. Circuit).[12] Medicare is a na-

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[12] Although the Ninth Circuit has clearly rejected the approach of the Eighth and Eleventh Circuits, see *Western Med. Enters.*, 783 F.2d at 1379-1380, it has not squarely addressed the equitable tolling issue. In

tionwide program and it should be governed by a uniform rule. At the same time, because any provider may seek judicial review of any final decision of the Board in the District Court for the District of Columbia, see 42 U.S.C. 1395*oo*(f)(1), the D.C. Circuit's decision in this case, if allowed to stand, would in itself have a broadly disruptive impact on the nationwide administration of the program. Cf. *Vermont Yankee*, 435 U.S. at 537 n.14 (noting that, because "the vast majority of challenges to administrative agency action are brought to the Court of Appeals for the District of Columbia Circuit, the decision[s of that court] serve as a precedent for many more proceedings for judicial review of agency actions than would the decision of another Court of Appeals").[13]

2. The court of appeals' decision is also in considerable tension with this Court's understanding and approval of the circumscribed reopening regime for Medicare providers as set forth in *Your Home*. In that case,

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Anaheim Memorial Hospital v. *Shalala*, 130 F.3d 845 (9th Cir. 1997), the court held that it lacked jurisdiction to review a provider's contention that the 180-day limit should be equitably tolled because the Board had not addressed that issue, and the court therefore remanded the case to the Secretary for a "final decision on the merits of [the plaintiff's] equitable tolling claim." *Id.* at 853. On remand, the PRRB determined that it lacked authority to equitably toll the statutory appeal period. See *Anaheim*, 2000 WL 1146514, at *13-*16; see p. 7, *supra* (noting that Board in this case relied in part on its decision in *Anaheim*).

[13] In its rulemaking leading to the 2008 amendment to the "good cause" regulation, HHS noted the "split among the Federal circuit courts of appeals on the threshold question of [the agency's] authority to authorize the Board to extend the 180-day period for hearing requests" pursuant to the regulation. 69 Fed. Reg. 35,725 (June 25, 2004). Although HHS considered "eliminating" the "good cause" regulation "altogether," it decided to "retain and revise" the regulation instead. *Ibid.*; see 73 Fed. Reg. at 30,205-30,207.

the Court held that reopening is discretionary when sought by the provider under 42 C.F.R. 405.1885 (1997), and that "[t]he right of a provider to seek reopening exists only by grace of the Secretary." *Your Home*, 525 U.S. at 454. "[G]iven the administrative realities," the Court explained that it "would not be shocked by a system in which underpayments could *never* be the basis for reopening." *Id.* at 455. Indeed, the Court noted, "[t]he few dozen fiscal intermediaries often need three years within which to discover overpayments in the tens of thousands of NPRs that they issue, while each of the tens of thousands of sophisticated Medicare-provider recipients of these NPRs is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Id.* at 455-456.

The court of appeals' ruling now allows those "tens of thousands of sophisticated Medicare-provider recipients" to evade the carefully circumscribed and clear limits of the reopening regulation, as well as the "good cause" regulation. The court's decision thus transforms a provider's ability to seek reopening (and "good cause" extensions) from a time-limited right existing solely by grace of the Secretary into an indefinite tolling regime defined by the courts under general principles of equity. The same "administrative realities" that caused this Court in *Your Home* to envision a Medicare payment scheme without *any* opportunity for reopening render the court of appeals' equitable tolling rule contrary to the statutory and regulatory scheme, as well as disruptive and highly burdensome. Cf. *Heckler* v. *Ringer*, 466 U.S. 602, 627 (1984) ("Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the

potential for overly casual or premature judicial intervention in an administrative system that processes literally millions of claims every year.").

3. The court of appeals' decision, if allowed to stand, will have substantial adverse effects on the orderly review of Medicare claims for payment.

For nearly 40 years, providers and the Medicare program have been operating under a statutory and regulatory scheme that required an appeal to the PRRB to be filed within 180 days of issuance of an NPR—or within three years if good cause is shown. The D.C. Circuit's decision now upends that regime and supplements it with an open-ended, judicially imposed equitable tolling exception that allows sophisticated providers to raise stale claims that could conceivably date back to the very inception of the Medicare program.

Respondents' claims alone cover cost years as far back as 1987. See p. 6, *supra*. And this is just the first of more than a dozen post-*Baystate* lawsuits in the District Court for the District of Columbia filed on behalf of hundreds of hospitals—all relying on equitable tolling and seeking recalculation of payment determinations made many years (and, oftentimes, a decade or more) ago. See App., *infra*, 11a-12a; *Forsyth Med. Ctr.* v. *Sebelius*, No. 10-1038 (D.D.C. filed June 17, 2010); *Bon Secours Health Sys., Inc.* v. *Sebelius*, No. 10-1406 (D.D.C. filed Aug. 20, 2010). Most of the other cases have been stayed pending the outcome of this case. See, *e.g.*, 5/21/10 Minute Order, *Aurora Sinai Med. Cntr. Inc* v. *Sebelius*, No. 09-0823 (D.D.C.). In addition, HHS has informed this Office that still more providers are now seeking equitable tolling before the PRRB on the *Baystate* issue with respect to Medicare cost reporting years long closed, and that since the court of appeals'

decision issued, providers have filed numerous new and untimely appeals with the PRRB relating to other payment issues and relying on equitable tolling.[14] This is not surprising because health care consulting firms and providers have every incentive to scour old cost reports looking for asserted reimbursement errors that, in the aggregate, could lead to claims for billions of dollars. The statute and regulations permit health care consulting firms to bring group appeals on behalf of large numbers of providers, see 42 U.S.C. 1395*oo*(b); 42 C.F.R. 405.1837, 405.1881 (2011), making the expenditure of resources a cost-effective private enterprise.

Even if provider appeals to equity ultimately fall short in particular cases, substantial resources would have to be devoted to adjudicating (at the Board level) and litigating (at the court level) untimely claims. See *Credit Suisse Sec.* v. *Simmonds*, No. 10-1261 (Mar. 26, 2012), slip op. 5, 7 (explaining that equitable tolling involves "fact-intensive disputes" about whether a litigant has diligently pursued his rights and whether "some extraordinary circumstance stood in his way").[15] As the

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[14] Other untimely appeals relying on equitable tolling were filed before the D.C. Circuit's decision and remain pending. See, *e.g.*, 3/5/12 Order, *Russel-Murray Hospice, Inc.* v. *Sebelius*, No. 10-5326 (D.C. Cir.) (case held in abeyance pending conclusion of settlement proceedings or filing of a petition for a writ of certiorari in this case).

[15] For similar reasons, the fact that the court of appeals' decision is interlocutory does not counsel against further review at this time. Regardless of whether it might ultimately be determined on remand that equitable tolling is inappropriate in this particular case, the decision below would remain binding precedent, and the agency would be required "to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for 'equitable tolling' which, upon close inspection, might turn out to lack sufficient equitable justification." See *Brockamp*, 519 U.S. at 352.

Secretary explained in revising and refining the "good cause" regulation, "[w]hen the Board finds good cause to extend the 180-day period for requesting a hearing, another case is added to the backlog" and "the lengthy 3-year period for requesting a good cause extension makes increases in the backlog more likely." 69 Fed. Reg. 35,725 (June 25, 2004); see 73 Fed. Reg. at 30,192 (backlog of approximately 6800 cases). The D.C. Circuit's decision, which extends well beyond the "lengthy 3-year period" and is considerably broader in scope than the "good cause" exception, would only further exacerbate the Board's backlog. An equitable tolling regime would thus take time and resources away from processing claims and appeals filed in compliance with the statutory and regulatory requirements, to the detriment of other Medicare providers.

By the same token, if the Board (or a court) were to determine that equitable tolling *is* appropriate in a particular case by virtue of the court of appeals' decision, intermediaries and the Board would then have to devote substantial additional resources to recalculating payment determinations for cost reporting periods that have long been closed. There are approximately 30,000 institutional providers participating in the Medicare program, including more than 6100 hospitals, see *2011 Stats*, Tbl. II.3, and each of those providers must file an annual cost report, see 42 C.F.R. 413.20(b), 413.24(f) (2011). A hospital cost report is complex, consisting of a variety of statistical schedules, numerous different worksheets, and detailed assembly instructions. See CMS, *The Provider Reimbursement Manual*, Pt. 2, ch. 36, 2011, http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html (last visited Apr. 13, 2012). Any

errors in calculations under the statutorily prescribed formula to determine the prospective rates could impact other providers subject to those rates. Payment calculations (and DSH payments in particular) are exceedingly complex, and intermediaries should not have to divert their limited and valuable auditing resources to reviewing and recalculating stale claims relating to NPRs from which the providers never bothered to appeal—or even sought to have reopened within the time allowed by the Secretary's regulations.

In addition, a requirement that equitable tolling be allowed would expose the Medicare program to claims of enormous amounts in the aggregate and make it more difficult for the Secretary and Congress to accurately gauge the financial status of the Medicare system when faced with open-ended claims from many years earlier. Allowing claims that can be a decade or more old would also reduce accuracy and increase uncertainty when determining providers' DSH allocations and ultimately inpatient PPS payments going forward. See, *e.g.*, *Methodist Hosp.*, 38 F.3d at 1229 (upholding as reasonable Secretary's longstanding policy of treating prospective-payment rate determinations as final and not generally subject to retroactive correction); *Palisades Gen. Hosp., Inc.* v. *Leavitt*, 426 F.3d 400, 404 (D.C. Cir. 2005) (upholding as reasonable Secretary's determination that retroactive corrections would result in an unsupportable administrative burden on the agency and disrupt the Secretary's already complex administration of the Medicare program).

* * * * *

This Court's review is warranted to correct the court of appeals' erroneous imposition of equitable tolling on the complex payment and administrative review scheme

established by Congress and the Secretary for the Medicare program, to resolve the conflict in the circuits concerning extensions of the 180-day period for filing administrative appeals, to bring judicial rulings governing the Medicare appeals process into conformity with this Court's decisions in *Your Home* and *Vermont Yankee*, and to prevent the imposition of substantial programmatic and financial burdens on the Medicare program.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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APRIL 2012

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
APPELLANTS

v.

KATHLEEN SEBELIUS, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEE

Argued: Dec. 7, 2010
Decided: June 24, 2011

Appeal from the United States District Court
for the District of Columbia
(No. 1:07-cv-02075)

OPINION

Before: HENDERSON and GRIFFITH, *Circuit Judges*, and WILLIAMS, *Senior Circuit Judge*.

Opinion for the Court filed by *Circuit Judge* GRIFFITH.

GRIFFITH, *Circuit Judge*: Since 1983, Medicare has used a prospective payment system to reimburse hospitals for their inpatient operating costs. These payments are based on predetermined, nationally applicable rates and are subject to various adjustments. One such adjustment is the disproportionate share hospital (DSH) payment, which provides an additional reimbursement to hospitals that serve large numbers of low-income patients. A hospital's DSH payment depends on its "DSH percentage," a figure that the Center for Medicare & Medicaid Services (CMS) must calculate. The DSH percentage varies based on the number of Medicare beneficiaries entitled to Supplementary Security Income, a federal low-income supplement established by the Social Security Act.

This case stems from the discovery in an unrelated case that CMS had paid hospitals less than they were due because it had miscalculated the DSH percentage for fiscal years 1993-1996. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The appellants in this case, a group of hospitals that receive DSH payments, filed claims with the Provider Reimbursement Review Board (PRRB) in 2006 seeking full payments for the fiscal years 1987-1994. Appellants acknowledged that they filed their claim more than a decade after the deadline for challenging payments, but argued that the limitations period should be equitably tolled because CMS knowingly and unlawfully failed to disclose that the DSH payments had been understated.

The PRRB held that it was without authority to toll the limitations period, making appellants' claim untimely and beyond the jurisdiction of the PRRB. Appellants then filed suit in the district court, which held that

it also lacked jurisdiction in this matter because the PRRB's determination was not a "final decision." The district court further held that the statute does not allow for equitable tolling. We take jurisdiction pursuant to 28 U.S.C. § 1291 and reverse and remand.

I

We consider first whether the PRRB's dismissal of appellants' claims for lack of jurisdiction was a "final decision." The Medicare statute grants "[p]roviders . . . the right to obtain judicial review of any final decision of the [PRRB] . . . by a civil action commenced within 60 days of the date on which notice of any final decision by the [PRRB] . . . is received." 42 U.S.C. § 1395oo(f). There is no question that this appeal was brought within sixty days. The only question is whether the PRRB's decision was final.

To understand the Secretary's argument, a word of explanation is needed about how providers receive Medicare reimbursements and how they can challenge those they think are wrong. Each year, Medicare providers submit cost reports to fiscal intermediaries, who then determine the amount of Medicare reimbursement due, which is announced in a Notice of Provider Reimbursement (NPR). If a provider is dissatisfied, it may appeal that determination to the PRRB but must do so within 180 days of the NPR. 42 U.S.C. § 1395oo(a). According to the Secretary and the district court, the Board's dismissal of an untimely claim is not a final decision. We fail to see how this could be the case. The district court thought this was our holding in *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982), but it was not. In *Athens*, we held that "*if the threshold requirements of 42 U.S.C. § 1395oo(f)(1) are*

met, a court has jurisdiction to review a decision by the PRRB that it lacks jurisdiction to review a determination of the fiscal intermediary." 686 F.2d at 994 (emphasis added). But § 1395oo(f)(1) only requires that "a civil action [be] commenced within 60 days" of the PRRB's "final decision." It says nothing about the 180-day limitations period.

The Secretary's confusion seems to stem from our reference to *John Muir Memorial Hospital, Inc. v. Califano*, 457 F. Supp. 848 (N.D. Cal. 1978)), in *Athens*. We stated there that "jurisdiction was not available to the court in *John Muir* because the provider failed to timely file its appeal. Under [§ 1395oo(f)(1)], a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision.'" 686 F.2d at 994 n.4. The Secretary reads this statement to suggest that a PRRB conclusion that it lacks jurisdiction over an untimely claim is not a final decision subject to judicial review. But that was not our point. In *John Muir*, the provider, without having appealed the fiscal intermediary's final determination to the PRRB within 180 days, went straight to the district court. It did not go there arguing the PRRB was wrong to deny jurisdiction. Rather, it argued the court could review the intermediary's decision on the merits pursuant to the grant of general federal question jurisdiction under 28 U.S.C. § 1331, even if a timely claim was never pressed before the PRRB. *See John Muir*, 457 F. Supp. at 852-53. The court disagreed, holding that it could only review cases on the merits that were filed within sixty days of a final decision by the PRRB. *See id.* The *John Muir* court did not hold that a dismissal for want of jurisdiction is not a final decision on that issue. And with good reason. Such a dismissal is final in any sense of the word. It is not

pending, interlocutory, tentative, conditional, doubtful, unsettled, or otherwise indeterminate. It is done.

Indeed, we took jurisdiction in *Athens* after explaining that courts have "jurisdiction to review a decision by the PRRB declining to hear a case on the basis of lack of PRRB jurisdiction." 686 F.2d at 993. If it were otherwise, "the PRRB could effectively preclude any judicial review of its decisions simply by denying jurisdiction of those claims that it deems to be non-meritorious." *Id.* (quoting *Cleveland Mem'l Hosp., Inc. v. Califano*, 444 F. Supp. 125, 128 (E.D.N.C. 1978), *aff'd*, 594 F.2d 993 (4th Cir. 1979)) (internal quotation marks omitted). Accordingly, courts of appeals in comparable situations have consistently understood dismissals for lack of jurisdiction as "final decisions." *See id.* (analogizing to 28 U.S.C. § 1291, where courts have consistently understood dismissals for lack of jurisdiction as final decisions). This approach accords not only with common sense but also with the relevant regulations. *Cf.* 42 C.F.R. § 405.1836(e)(2) ("A Board dismissal decision under paragraph (e)(1) [which concerns dismissals for 'lack of Board jurisdiction'] of this section is final and binding on the parties. . . . "). We reaffirm, then, that a decision of the PRRB denying jurisdiction is a final decision subject to judicial review.

II

The hospitals' claims, brought over a decade after the statute of limitations had expired, may only be heard by the PRRB if the limitations period can be equitably tolled. As we recently reiterated, "It is hornbook law that limitations periods are customarily subject to equitable tolling unless tolling would be inconsistent with the text of the relevant statute." *Menominee Indian Tribe*

of Wis. v. United States, 614 F.3d 519, 529 (D.C. Cir. 2010) (internal quotation marks omitted). In general, "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States," *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), and the presumption of equitable tolling is not disturbed by the fact that Medicare is a government benefits program, *see, e.g.*, *Scarborough v. Principi*, 541 U.S. 401, 422 (2004).[1]

The district court rejected equitable tolling on the ground that "plaintiffs have proffered nothing suggesting that . . . Congress intended to authorize equitable tolling for provider claims." *Auburn Reg'l Med. Ctr. v. Sebelius*, 686 F. Supp. 2d 55, 70 (D.D.C. 2010). Subsequently, *Menominee* made clear that the appropriate inquiry is just the opposite: whether there was good reason to think Congress did *not* want equitable tolling.

This presumption in favor of equitable tolling holds here. The statute specifies that "[a]ny provider of services which has filed a required cost report within the

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[1] We have also required that the injury be "of a type familiar to private litigation." *Menominee*, 614 F.3d at 529 (quoting *Chung v. DOJ*, 333 F.3d 273, 277 (D.C. Cir. 2003)). Following the Supreme Court's recent decision in *Holland v. Florida*, 130 S. Ct. 2549 (2010), it is not entirely clear how similar the claim must be to "private litigation" for equitable tolling to apply. The Court in *Holland* applied the presumption of equitable tolling to a limitations period in the Antiterrorism and Effective Death Penalty Act without first identifying a private-litigation equivalent, stating simply that "a nonjurisdictional federal statute of limitations is normally subject to a 'rebuttable presumption' in favor 'of equitable tolling.'" *Id.* at 2560. In any event, the contours of that requirement need not be determined now, as this case is "of a type familiar to private litigation" because it is analogous to a contract claim.

time specified in regulations may obtain a hearing with respect to such cost report . . . if . . . such provider files a request for hearing within 180 days after notice of the intermediary's final determination." 42 U.S.C. § 1395oo(a). This language is similar to other statutes that have been held to permit equitable tolling. *See Menominee*, 614 F.3d at 529-31 (finding equitable tolling permissible where statute required all claims to "be submitted within 6 years after the accrual of the claim"); *see also Irwin*, 498 U.S. at 94-96 (finding equitable tolling permissible where statute stated that "[w]ithin thirty days of receipt of notice of final action . . . an employee . . . may file a civil action"); *Kirkendall v. Dep't of Army*, 479 F.3d 830, 837-42 (Fed. Cir. 2007) (en banc) (finding equitable tolling permissible where statute provided that "within 60 days after the date on which [the complaint] is filed, the complainant may elect to appeal . . . except that in no event may any such appeal be brought . . . before the 61st day after the date on which the complaint is filed").

The Secretary argues that the presumption is rebutted here, relying upon *United States v. Brockamp*, 519 U.S. 347 (1997). In *Brockamp*, the Supreme Court found that the statute of limitations for filing tax refund claims, IRC § 6511, cannot be equitably tolled. But the Court in *Brockamp* did so by pointing to a number of factors not present here. First, the Court observed that ordinarily, "limitations statutes use fairly simple language," citing as an example 42 U.S.C. § 2000e-16(c), which provides that a suit must be filed "[w]ithin 90 days of receipt of notice of final [EEOC] action." 519 U.S. at 350. By contrast, the Court reasoned, the language in IRC § 6511 is "not simple," but instead "sets forth its limitations in a highly detailed technical manner," *id.*,

and "reiterates its limitations several times in several different ways," *id.* at 351.[2] Also unlike the statute at issue here, IRC § 6511 "sets forth explicit exceptions to its basic time limits," *id.*, including special time-limit rules for "refunds related to operating losses, credit carrybacks, foreign taxes, self-employment taxes, worthless securities, and bad debts." *Id.* at 351-52. In the detailed landscape of exceptions before the Court in *Brockamp*, there was no reference to equitable tolling —a fact the Court found particularly conspicuous given that "[t]ax law . . . is not normally characterized by case-specific exceptions reflecting individualized equities." *Id.* at 352. These reasons, "taken together, indicate[d] . . . that Congress did not intend courts to

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[2] IRC § 6511 begins by stating that a "[c]laim for . . . refund . . . of any tax . . . shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed . . . within 2 years from the time the tax was paid." IRC § 6511(a). It reiterates that "[n]o credit or refund shall be allowed or made after the expiration of the period of limitation prescribed . . . unless a claim for . . . refund is filed . . . within such period." *Id.* § 6511(b)(1). It again states that "[i]f the claim was filed by the taxpayer during the 3-year period . . . the amount of the credit or refund shall not exceed the portion of the tax paid within the period, immediately preceding the filing of the claim, equal to 3 years plus the period of any extension of time for filing the return . . . ." *Id.* § 6511(b)(2)(A). Later, § 6511 provides that "[i]f the claim was not filed within such 3-year period, the amount of the credit or refund shall not exceed the portion of the tax paid during the 2 years immediately preceding the filing of the claim." *Id.* § 6511(b)(2)(B). As the *Brockamp* Court noted, the tax code also "reemphasizes the point when it says that refunds that do not comply with these limitations 'shall be considered erroneous,' and specifies procedures for the Government's recovery of any such 'erroneous' refund payment." 519 U.S. at 351 (citations omitted).

read other, unmentioned, open-ended 'equitable' exceptions into the statute that it wrote." *Id.*

The statute in this case is different enough from the one in *Brockamp* for us to conclude that the presumption of equitable tolling has not been rebutted. First, the language in § 1395oo resembles the "fairly simple language" in § 2000e-16(c) that the *Brockamp* Court said clearly allowed equitable tolling. *Compare* 42 U.S.C. § 1395oo(a) (allowing "any provider of services which has filed a required cost report within the time specified in regulations [to] obtain a hearing . . . if . . . such provider files a request for hearing within 180 days after notice of the intermediary's final determination") *with id.* § 2000e-16(c) (stating that a suit must be filed "[w]ithin 90 days of receipt of notice of final [agency] action"). Second, although the statute of limitations here has a "good cause" exception that lasts no longer than three years, that exception is in the regulations, not the statute, *see* 42 C.F.R 405.1841(b) (2007), and does not bear on whether Congress rebutted the presumption of equitable tolling by enacting a complex set of exceptions to the statute of limitations. In any event, that one exception is unlike the numerous "highly technical" exceptions in the Internal Revenue Code, and is not "reiterate[d] . . . several times in several different ways." *Brockamp*, 519 U.S. at 350-51. Furthermore, contrary to the Secretary's suggestions, the Court's focus in *Brockamp* was not the complexity of tax law per se, but rather the complexity of the provisions governing whether and when a claim could be filed. *Menominee*, 614 F.3d at 530 ("[F]ocus on the regulatory scheme as a whole is misplaced. The *Brockamp* Court did not concern itself with the complexity of the Tax Code as a whole, but the complexity of the time limitations found

in § 6511."). It is true that as a general matter, the Medicare statute, like the Internal Revenue Code, is quite complex. But unlike the tax code, the Medicare statute does not create a detailed Jenga tower of deadlines and exceptions that equitable tolling might topple. Rather, its timing scheme is straightforward and readily amenable to tolling.

Given that the factors emphasized in *Brockamp* do not apply to the facts presented here, and without any other reasons for rebutting the presumption of equitable tolling, we find that equitable tolling is available under § 1395oo(a). Whether tolling is appropriate in this particular case, however, is a different question that cannot be answered without further factual development. That question is for the district court on remand.

Appellants also raise alternative arguments about the availability of mandamus and general federal question jurisdiction in the event that equitable tolling is not available. Given our disposition, we need not reach those arguments today.

III

For the foregoing reasons, we reverse and remand for further proceedings consistent with this opinion.

So ordered.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 07-2075 (JDB)

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
PLAINTIFFS

v.

KATHLEEN SEBELIUS, SECRETARY,
UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES, DEFENDANT

Filed: Mar. 11, 2010

AMENDED MEMORANDUM OPINION

The Secretary of the Department of Health and Human Services, through the Centers for Medicare and Medicaid Services ("CMS"), is responsible for providing payments known as "disproportionate share hospital" ("DSH") adjustments to hospitals that serve a significantly disproportionate share of low income patients, as set forth under the Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. Hundreds of Medicare providers have, collectively, filed twelve lawsuits in this district to obtain recalculation of their DSH payments as a result of findings made by the Provider Reimbursement Review Board on March 17, 2006,

concerning systemic flaws in the data used by CMS and in the process used to assess the data. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, Case Nos. 96-1822; 97-1579; 98-1827; 99-2061, Decision No. 2006-D20 (Mar. 17, 2006) (Pl.'s Mem., Ex. A) ("*Baystate* Board Decision"). Those findings were reviewed by this Court, and sustained in part, as set forth in an opinion issued on March 31, 2008. *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *amended in part*, 587 F. Supp. 2d 37 (D.D.C. 2008).

In this first of the post-*Baystate* lawsuits, seventeen Medicare providers seek judicial relief from allegedly erroneous DSH payment determinations for fiscal years 1987-1994. Plaintiffs filed administrative appeals of those DSH determinations with the Board on September 12, 2006. *See* Compl. ¶ 52. They requested "equitable tolling" of the 180-day limitations period for filing such appeals, recognizing that, absent such tolling, their appeals would be barred by the 180-day deadline set forth in 42 U.S.C. § 1395oo(a). The Board dismissed their appeals as untimely, holding, *inter alia*, that it lacked authority to grant a request for equitable tolling. *See In re Crowell & Moring 87-93 DSH Equitable Tolling Group*, Case No. 06-2357G (Sept. 18, 2007) (Compl., Ex. B) ("*In re Equitable Tolling Group*, Board Decision"). Plaintiffs contend that the Board's decision was contrary to law and ask this Court to hold their administrative appeals timely. Compl. ¶¶ 59-60. In the alternative, they seek an order from this Court directing the Secretary to order the Medicare fiscal intermediaries "to make new DSH determinations for the FYs at issue . . . using correct . . . percentages" through a grant of mandamus or similar order under the Mandamus Act, 28 U.S.C. § 1361, the All Writs Act, 28 U.S.C. § 1651, or

the federal question statute, 28 U.S.C. § 1331. *Id.* ¶¶ 61-64.

In response, defendants have moved to dismiss the complaint on the ground that plaintiffs' administrative appeals were untimely and hence, judicial review is not available under § 1395oo(f). Defendants further contend that plaintiffs are not entitled to mandamus relief under § 1361 or any other statute because they have failed to identify a nondiscretionary duty owed to plaintiffs or otherwise satisfied the extraordinary requirements for mandamus relief. A hearing on defendant's motion was held on January 21, 2010. For the reasons explained below, the Court will grant defendant's motion to dismiss.[1]

BACKGROUND

I. Statutory and Regulatory Background

Through a complex statutory and regulatory regime, the Medicare program reimburses qualifying hospitals for the services they provide to eligible elderly and disabled patients. *See generally County of Los Angeles v. Shalala*, 192 F.3d 1005, 1008 (D.C. Cir. 1999). The "operating costs of inpatient hospital services" are reimbursed under a prospective payment system ("PPS")—that is, based on prospectively determined standardized rates—but subject to hospital-specific adjustments. 42 U.S.C. § 1395ww(d); *see generally In re Medicare Reimbursement Litig.*, 309 F. Supp. 2d 89, 92 (D.D.C. 2004), *aff'd*, 414 F.3d 7, 8-9 (D.C. Cir. 2005). One such

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[1] For ease of reference, the memorandum in support of defendant's motion to dismiss and reply brief will be cited as "Def.s' Mem.," and "Def.s' Reply," respectively. Plaintiffs' opposition brief will be cited as "Pls.' Mem."

adjustment is the "disproportionate share hospital" ("DSH") adjustment which requires the Secretary to provide an additional payment to each hospital that "serves a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends on the "disproportionate patient percentage" determined by the Secretary under a statutory formula. 42 U.S.C. § 1395ww(d)(5)(F)(v)-(vii). This percentage is a "proxy measure for low income." *See* H.R. Rep. No. 99-241, at 16-17 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 594-95.

The disproportionate patient percentage is the sum of two fractions, commonly referred to as the Medicaid fraction (often called the Medicaid Low Income Proxy) and the Medicare fraction (the Medicare Low Income Proxy). 42 U.S.C. § 1395ww(d)(5)(F)(vi); *Jewish Hospital, Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270, 272 (6th Cir. 1994). The Medicare fraction—the focus of this litigation—reflects the number of hospital inpatient days attributable to Medicare Part A patients who are also entitled to Supplemental Security Income ("SSI") benefits at the time of their hospital stays, and, hence, is often referred to as the SSI fraction or SSI percentage. *See Baystate*, 545 F. Supp. 2d at 22-23. A detailed description of the data underlying the SSI fraction and the methodology used by CMS is set forth in this Court's *Baystate* decision.[2] *See* 545 F. Supp. 2d at 23-24. It is sufficient to state here that cal-

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[2] CMS was known as the Health Care Financing Administration during the fiscal years at issue. Hence, the references to CMS throughout this opinion encompass HCFA as well.

culation of the numerator of the SSI fraction requires use of voluminous SSI data from the Social Security Administration, and that CMS has taken on sole responsibility for computation of the SSI fraction. *Id.* (citing 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986) (DSH final rule)).

Medicare payments are initially determined by a "fiscal intermediary"—typically an insurance company that acts as the Secretary's agent for purposes of reimbursing health care providers. *See* 42 C.F.R. §§ 421.1, 421.3, 421.100-.128.[3] A fiscal intermediary is required by regulation to apply the SSI fraction computed by CMS. *See id.* § 412.106(b)(2) and (b)(5). The intermediary sets forth the total payment—including any DSH payment—due to a provider for a particular fiscal year in a Notice of Program Reimbursement ("NPR"). *Id.* § 405.1803.

A provider dissatisfied with the amount of the award may request a hearing before the Provider Reimbursement Review Board ("PRRB" or "Board"), an administrative body composed of five members appointed by the Secretary. 42 U.S.C. § 1395oo(a), (h). Section 1395oo(a)(3) provides that such appeals must be filed "within 180 days after notice of the intermediary's final determination." The PRRB has the authority to affirm, modify, or reverse the final determination of the intermediary, and the Secretary may then reverse, affirm, or modify the Board's decision within 60 days thereafter.

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[3] The citations to the Code of Federal Regulations are to the 2007 version in effect at the time the Board issued the decision under review. Defendant notes that the Secretary has amended the regulations since then, but the applicability of the amendments is limited to "'appeals pending as of, or filed on or after, August 21, 2008,'" with exceptions not applicable here. *See* Def.'s Mem. at 6 n.3 (quoting 73 Fed. Reg. 30,190 (May 23, 2008)). Plaintiffs agree that the 2007 version applies. Pls.' Mem. at 21.

Id. § 1395oo(d) and (f). Providers may obtain judicial review of "any final decision of the Board" or the Secretary's reversal, affirmance, or modification thereof, by commencing a civil action within 60 days of receipt of any final decision. *Id.* § 1395oo(f).

The Secretary has, by regulation, authorized the Board to grant an extension of the 180-day administrative appeal period "for good cause shown," if a request for extension is filed not "more than 3 years after the date the notice of the intermediary's determination is mailed to the provider." 42 C.F.R. § 405.1841(b). The regulation prohibits the Board from extending the 180-day deadline for administrative appeals if the request is submitted after that three-year period. *Id.*

Apart from the administrative appeal process, a provider also may obtain administrative relief from an intermediary's determination by requesting a "reopening." In most instances, a request for reopening must be submitted within three years of the date of the intermediary determination or Board decision at issue, but in cases of "fraud or similar fault of any party to the determination," the three-year deadline does not apply. *See* 42 C.F.R. § 405.1885(a), (d); *see generally Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 809 (D.C. Cir. 2001). The regulations provide that reopening is discretionary in some circumstances and mandatory in others. 42 C.F.R. § 405.1885(a)-(b), (d). Hospitals may not seek judicial review of an intermediary's denial of a motion to reopen because a refusal to reopen is not a "final determination . . . as to the amount" reviewable by the Board under § 1395oo(a)(1), but rather is a refusal to make a new determination. *Your Home Visiting Nurse*

Servs., Inc. v. *Shalala*, 525 U.S. 449, 453 (1999); *accord*, *Monmouth*, 257 F.3d at 811.

II. Factual Background

Plaintiffs are various hospitals who participated in the Medicare program at various times between fiscal years 1987 through 1994. Compl. ¶¶ 4-11. Each hospital received a Notice of Program Reimbursement setting forth its DSH payment determination, which typically occurs within two to three years of the end of a fiscal year. *Id.* ¶¶ 50-51, 53; *see Baystate Med. Ctr.*, 545 F. Supp. 2d at 42.[4] None of the plaintiffs filed an administrative appeal within 180 days of receipt of the NPRs. Compl. ¶ 53.

On March 17, 2006, over ten years after the fiscal years at issue, the PRRB addressed whether there were systemic flaws in the data underlying the DSH payment determinations in the context of resolving the claims of Baystate Medical Center—a nonparty to this case—which had lodged a timely appeal of its DSH payments for fiscal years 1993 through 1996. 545 F. Supp. 2d at 26-30. Baystate had alleged that certain categories of SSI eligibility records were omitted from the data tapes used by CMS to calculate the SSI fraction of the DSH percentage and that the patient identifiers used by CMS resulted in undercalculation of the SSI fraction. *Id.* The Board found, *inter alia*, that several categories of SSI eligibility data had been omitted from the CMS calcula-

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[4] The complaint is silent on the exact date the NPRs were issued. Defendant represents that the NPRs were issued during the 1989-1996 time frame, consistent with the two-to-three year cost settlement process described in *Baystate*, and plaintiffs have not disputed this. *See* Def.'s Mem. at 7. The exact dates are not, in any event, material to the resolution of defendant's motion.

tions, that the "match process" used by CMS to determine the number of SSI eligible Medicare beneficiaries was flawed, and that these omissions and flaws tended to deflate the overall DSH payment. *Id.* The Board thus remanded the case to the intermediary for recalculation of Baystate's DSH payment. *Id.* at 30. The Board's findings subsequently underwent additional administrative and judicial review, resulting in this Court's decision in the *Baystate* litigation, which left the Board's findings concerning the omissions in data and flaws in the match process largely intact. *See* 545 F. Supp. 2d at 40-55.[5]

On September 12, 2006, about three months after the Board's *Baystate* decision, plaintiffs appealed their DSH payment determinations to the Board on the ground that the determinations were made using an understated SSI fraction. Compl. ¶ 52. They acknowledged that each of their appeals was filed more than three years after the NPRs had been issued. *Id.* ¶ 53. However, plaintiffs asked the Board to find the appeals timely under the principle of equitable tolling. *Id.* ¶ 54. They contended that equitable tolling applied because the hospitals' failure to file an appeal within 180 days of issuance of the NPRs was the result of CMS's refusal to inform the hos-

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[5] The CMS Administrator, acting for the Secretary, reversed the Board's decision granting relief to Baystate, reasoning that CMS had relied on the "best available data" and that the omissions were not significant. *Baystate*, 545 F. Supp. 2d at 31-34. Baystate then sought judicial review in this Court. On cross-motions for summary judgment, the Court held, in relevant part, that the Administrator acted arbitrarily and capriciously in finding that CMS had relied on the "best available data" to calculate the SSI fraction because several categories of SSI eligibility data available to CMS had been excluded from the calculations. *Id.* at 40-50.

pitals that their SSI percentages were incorrectly understated for the fiscal years at issue, citing the Board's *Baystate* decision. *Id.* ¶ 55. In their view, then, the appeals were timely because they were filed within 180 days of the Board's *Baystate* decision. *Id.* ¶¶ 54-56.

On September 18, 2007, the Board held that it lacked jurisdiction over the hospitals' appeals because they were not timely filed. *See In re Equitable Tolling Group*, Board Decision at 3. The Board reasoned that it had only the powers granted to it by statute and regulation, which limited its authority to hear an administrative appeal to requests filed within 180 days of the date of the final determination (42 U.S.C. § 1395oo(a)) or requests demonstrating "good cause" for a late appeal within three years after the intermediary's determination was mailed to the provider (42 C.F.R. § 405.1841(b)). *Id.* The Board determined that "[g]ood cause for late filing cannot be considered in these cases because the cases [were] filed more than three years after the issuance of the NPRs . . . ." *Id.* at 2. The Board further concluded that it did not have "general equitable powers," but instead was limited to the equitable powers granted by § 405.1841(b), as well as the reopening regulation, § 405.1885. *Id.* Therefore, the Board held the appeals untimely. *Id.* at 3. The Secretary declined to review the Board's decision. *See* Compl., Ex. B. Plaintiffs then brought this action seeking judicial review pursuant to § 1395oo(f) or, in the alternative, a judicial order directing the Secretary to order the Medicare fiscal intermediaries "to make new DSH determinations for the FYs at issue . . . using correct SSI percentages" through a grant of mandamus. Plaintiffs also contend that their challenges may be re-

viewed directly under the federal question statute if judicial review is not available elsewhere.

STANDARD OF REVIEW

"[I]n passing on a motion to dismiss, whether on the ground of lack of jurisdiction over the subject matter or for failure to state a cause of action, the allegations of the complaint should be construed favorably to the pleader." *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974); *see Leatherman v. Tarrant Cty. Narcotics and Coordination Unit*, 507 U.S. 163, 164 (1993); *Phillips v. Bureau of Prisons*, 591 F.2d 966, 968 (D.C. Cir. 1979). Therefore, the factual allegations must be presumed true, and plaintiff must be given every favorable inference that may be drawn from the allegations of fact. *Scheuer*, 416 U.S. at 236; *Sparrow v. United Air Lines, Inc.*, 216 F.3d 1111, 1113 (D.C. Cir. 2000). However, the Court need not accept as true "a legal conclusion couched as a factual allegation," nor inferences that are unsupported by the facts set out in the complaint. *Trudeau v. Federal Trade Comm'n*, 456 F.3d 178, 193 (D.C. Cir. 2006) (quoting *Papasan v. Allain*, 478 U.S. 265, 286 (1986)).

Under Rule 12(b)(1), the party seeking to invoke the jurisdiction of a federal court—plaintiffs here—bears the burden of establishing that the court has jurisdiction. *See US Ecology, Inc. v. U.S. Dep't of Interior*, 231 F.3d 20, 24 (D.C. Cir. 2000); *see also Grand Lodge of Fraternal Order of Police v. Ashcroft*, 185 F. Supp. 2d 9, 13 (D.D.C. 2001) (a court has an "affirmative obligation to ensure that it is acting within the scope of its jurisdictional authority."); *Pitney Bowes, Inc. v. United States Postal Serv.*, 27 F. Supp. 2d 15, 19 (D.D.C. 1998). "'[P]laintiff's factual allegations in the complaint . . .

will bear closer scrutiny in resolving a 12(b)(1) motion' than in resolving a 12(b)(6) motion for failure to state a claim." *Grand Lodge*, 185 F. Supp. 2d at 13-14 (quoting 5A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 1350 (2d ed. 1987)). Additionally, a court may consider material other than the allegations of the complaint in determining whether it has jurisdiction to hear the case, as long as it still accepts the factual allegations in the complaint as true. *See Jerome Stevens Pharm., Inc. v. FDA*, 402 F.3d 1249, 1253-54 (D.C. Cir. 2005); *EEOC v. St. Francis Xavier Parochial Sch.*, 117 F.3d 621, 624-25 n.3 (D.C. Cir. 1997); *Herbert v. Nat'l Acad. of Scis.*, 974 F.2d 192, 197 (D.C. Cir. 1992).

In reviewing a motion to dismiss pursuant to Rule 12(b)(6), the Court is mindful that all that the Federal Rules of Civil Procedure require of a complaint is that it contain "'a short and plain statement of the claim showing that the pleader is entitled to relief,' in order to 'give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.'" *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (quoting *Conley v. Gibson*, 355 U.S. 41, 47 (1957)); *accord Erickson v. Pardus*, 551 U.S. 89, 93 (2007) (per curiam). Although "detailed factual allegations" are not necessary to withstand a Rule 12(b)(6) motion to dismiss, to provide the "grounds" of "entitle[ment] to relief," a plaintiff must furnish "more than labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Twombly*, 550 U.S. at 555-56; *see also Papasan v. Allain*, 478 U.S. 265, 286 (1986). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. ___,

129 S. Ct. 1937, 1949 (2009) (quoting *Twombly*, 550 U.S. at 570); *Atherton v. District of Columbia Office of the Mayor*, 567 F.3d 672, 681 (D.C. Cir. 2009). A complaint is plausible on its face "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 129 S. Ct. at 1949.

In resolving a motion to dismiss an action for relief in the nature of mandamus, courts have characterized the issue as involving both a jurisdictional and a merits inquiry because, in determining whether the court has jurisdiction to compel an agency or official to act, the court must consider the merits question of whether a legal duty is owed to the plaintiff under the relevant statute. *See In re Cheney*, 406 F.3d 723, 729 (D.C. Cir. 2005) (en banc) (noting that to the extent a court considers whether a statute creates a duty, "mandamus jurisdiction under [28 U.S.C.] § 1361 merges with the merits"). Whether a motion to dismiss a mandamus action should be considered pursuant to Rule 12(b)(1) or Rule 12(b)(6) is a matter on which there are "conflicting signals,"[6] but *In re Cheney* indicates that the better course is to consider the matter a merits issue, both in the court's characterization of the jurisdictional and merits inquiries as "merged" and in the purposeful manner in which it limited its review of the record to the sufficiency of the complaint and the documents attached thereto. *Id.* at 729-30. Therefore, with respect to the mandamus claim, defendant's motion to dismiss will be considered pursuant to Rule 12(b)(6).

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[6] *See Ahmed v. Dep't of Homeland Security*, 328 F.3d 383, 386-87 (7th Cir. 2003); *Swan v. Clinton*, 100 F.3d 973, 976-77 n.1 (D.C. Cir. 1996).

DISCUSSION

I. Availability of Judicial Review Under 42 U.S.C. § 1395oo(f)

Defendant raises the threshold issue of whether the Court has jurisdiction under the Medicare Act, 42 U.S.C. § 1395oo(f), to review the Board's decision. Defendant contends that § 1395oo(f) limits judicial review to a "final decision of the Board," and that under *Athens Comm. Hosp. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982),[7] a Board decision dismissing an appeal based on expiration of the 180-day statutory deadline is not a "final decision" within the meaning of the statute. *See* Def.'s Mem. at 9-11; Def.'s Reply at 3-7. Plaintiffs respond that the 180-day limitations period is not a jurisdictional hurdle subject to Rule 12(b)(1) scrutiny, but is instead properly construed as a statute of limitations that, like other limitations periods, is subject to equitable tolling. Pls.' Mem. at 13-16. Plaintiffs further counter that *Athens* confirms that judicial review of the Board's dismissal decision is available under § 1395oo(f), and posit that defendant has misconstrued *Athens*. *Id.* at 16-19. Resolution of defendant's motion requires a close examination of the language of both § 1395oo and *Athens*.

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[7] *Athens Comm. Hosp.* was modified on rehearing with respect to an issue unrelated to this "final decision" question. *See* 743 F.2d 1 (D.C. Cir. 1984). The modified opinion was later overruled by the Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). The parties presume that the original *Athens* opinion remains the governing law of this circuit on what constitutes a "final decision" subject to judicial review, and the Court agrees. A careful review of those subsequent decisions shows that the "final decision" analysis set forth in the original *Athens* opinion was not subsequently called into question.

The relevant statutory language is as follows:

> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a [PRRB] . . . and any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww . . . may obtain a hearing with respect to such payment by the Board, if—
>
> > (3) such provider files a request for hearing *within 180 days after notice of the intermediary's final determination* . . .
> >
> > . . .
> >
> > (f) . . . Providers shall have the right to obtain judicial review of *any final decision of the Board* . . . by a civil action commenced within 60 days of the date on which notice of *any final decision by the Board* . . . is received. . . . .

42 U.S.C. § 1395oo (emphasis added). At the outset, it is important to note that the 180-day limitations period cannot plausibly be characterized as jurisdictional. First and foremost, there is no language in § 1395oo(a) or (f) indicating that the limitations period is jurisdictional. The Supreme Court has cautioned that, "when Congress does not rank a statutory limitation . . . as jurisdictional, courts should treat the restriction as nonjurisdictional in character." *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 515-16 (2006); *see also Union Pacific R. Co. v. Bhd. of Locomotive Eng'rs and Trainmen Gen. Comm. of Adjustment*, 130 S. Ct. 584, 596 (2009) ("Recognizing that the word 'jurisdiction' has been used by courts, including this Court, to convey 'many, too

many, meanings,' we have cautioned, in recent decisions, against profligate use of the term. Not all mandatory 'prescriptions, however emphatic, are . . . properly typed jurisdictional.'") (quoting *Arbaugh*, 546 U.S. at 510); *Oryszak v. Sullivan*, 576 F.3d 522, 525 & n.2 (D.C. Cir. 2009) (describing *Arbaugh* as holding that a "limitation on [a] cause of action that 'does not speak in jurisdictional terms or refer in any way to the jurisdiction of the district courts' is not jurisdictional"). Second, the agency has promulgated regulations authorizing extension of the 180-day period for good cause, if such a request is filed within three years of issuance of the NPR. *See* 42 C.F.R. § 405.1841(b). If the statutory 180-day period were jurisdictional, the Board could not enlarge it by rule.

Ultimately, however, defendant's argument against judicial review under § 1395oo(f) does not depend on whether the 180-day limitations period is characterized as "jurisdictional" or as a nonjurisdictional prerequisite to obtaining relief. Even in the latter case, the Court still must consider whether a Board decision dismissing an appeal based on expiration of the 180-day limitations period is a "final decision" subject to judicial review. Resolution of what constitutes a "final decision" subject to judicial review requires close examination of *Athens*.

In *Athens*, the provider had filed a timely administrative appeal challenging several cost adjustments in its Notice of Program Reimbursement, and later sought to amend its appeal to include additional categories of costs that it had not originally sought from the intermediary. 686 F.2d at 992-93. The Board held that it lacked jurisdiction to consider the new claims. *Id.* The court considered in that context "whether a decision by the

PRRB not to exercise jurisdiction is a 'final decision' sufficient to establish [the court's] jurisdiction" under § 1395oo(f). *Id.* at 993. The court held "*if the threshold requirements of 42 U.S.C. § 1395oo(f)(1) are met*, a court has jurisdiction to review a decision by the PRRB that it lacks jurisdiction to review a determination of the fiscal intermediary." *Id.* at 994 (emphasis added). Hence, the court held that it had jurisdiction to review the PRRB decision before it, because an appeal had been filed with the Board within the 180-day limitations period and the other threshold statutory requirements had been satisfied.

Athens left no doubt that it considered one of the essential "threshold requirements" giving rise to a "final decision" to be the filing of an administrative appeal within the 180-day limitations period. This is made clear from the court's approval of the district court's dismissal of an untimely challenge to a PRRB decision in *John Muir Mem. Hosp. v. Califano*, 457 F. Supp. 848 (N.D. Cal. 1978). The court in *Athens* explained that "in *John Muir* . . . the question was whether the Board had jurisdiction to hear an appeal from an intermediary's decision" where an appeal had *not* been filed with the Board within the 180-day limitations period. 686 F.2d at 993. It found *John Muir* was "easily distinguished" from the outcome in *Athens* because "42 U.S.C. § 1395oo(f)(1) jurisdiction was not available to the court." *Id.* at 993-94 (discussing *John Muir*, 457 F. Supp. at 853). The court elaborated in a footnote that "[§ 1395oo(f)] jurisdiction was not available to the court in *John Muir because the provider failed to timely file its appeal.* Under the statute, a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision.'" *Id.* at 994 n.4 (emphasis added).

In light of *Athens*' express reference to satisfaction of "the threshold requirements of 42 U.S.C. § 1395oo(f)(1)," and its statement in footnote 4 that, with respect to a "provider [who] failed to timely file its appeal . . . a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision,'" *Athens* is properly understood as holding that a plaintiff may obtain judicial review of a PRRB refusal to exercise jurisdiction only if an administrative appeal has been filed within the 180-day limitations period.

Admittedly, this reading does not lead to the most intuitive result. The PRRB decision at issue has the hallmarks of decisions that are commonly considered "final" in other areas of the law. For example, it marks the consummation of the agency's decisionmaking process and is an action that results in rights having been determined. *See Bennett v. Spear*, 520 U.S. 154, 177-78 (1997) (discussing requirements of "final agency action" within the meaning of the Administrative Procedure Act). Indeed, both the Board and the Secretary presumed that the Board decision would be subject to judicial review. *See In re Equitable Tolling Group*, Board Decision at 3 ("Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1)"); Letter from CMS to Robert Roth, dated Nov. 1, 2007 (referring to availability of judicial review within 60 days of Board decision) (Compl., Ex. B). Moreover, as *Athens* observed, "[judicial] dismissals for lack of jurisdiction consistently have been understood as 'final decisions,'" and by analogy, Board dismissals also may be considered final decisions. 686 F.2d at 993 (discussing *Cleveland Mem. Hosp. v. Califano*, 444 F. Supp. 125 (E.D.N.C. 1978), *aff'd*, 594 F.2d 993 (4th Cir. 1979)).

Indeed, *Athens* approved of the determination in *Cleveland* that a PRRB dismissal order based on failure to satisfy the § 1395oo(a) amount-in-controversy provision—another threshold statutory requirement—was a "final decision" within the meaning of that statute. Hence, there is some tension in the conclusion that the PRRB decision in *Cleveland* was a "final decision," but the PRRB decision in *John Muir* was not. One can reconcile that tension in perhaps two ways: first, as defendant suggested at the motions hearing here, the 180-day limitations period stands in a different stead than the amount-in-controversy requirement because of the government's recognized interest in imposing finality on the Medicare reimbursement process;[8] and second, where there is a "real dispute" over whether a threshold requirement of § 1395oo(f) is satisfied, such as with the amount-in-controversy in *Cleveland* (in contrast to the parties' agreement in *Muir* that 180 calendar days from the final NPR had run), then the Board's resolution of that issue will constitute a judicially reviewable "final decision." *See St. Joseph's Hosp. of Kansas City v. Heckler*, 786 F.2d 848, 852 (8th Cir. 1986). Neither explanation is entirely satisfactory, but the Court need not choose between those explanations, nor identify another, in light of the clear decision in *Athens*.

This Court must follow *Athens'* instruction that, with respect to a "provider [who] failed to timely file its appeal . . . a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision.'" *Athens*, 686 F.2d at 994 & n.4. Plaintiffs concede that they

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[8] As defendant noted at the motions hearing, this interest was recognized in *Califano v. Sanders*, 430 U.S. 99, 108 (1977), and *Your Home Visiting Nurse Servs.*, 525 U.S. at 453.

filed their appeals to the Board "more than three years after the Medicare NPRs had been issued for each of the FYs at issue." Compl. ¶ 53. Hence, under *Athens*, the Board decision dismissing their appeals as untimely is not a "final decision" within the meaning of § 1395oo(f), and is accordingly not subject to judicial review.[9]

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[9] This understanding of *Athens* is in accord with the decisions of other courts that have considered the consequences of a provider's failure to comply with the 180-day limitations period, notwithstanding a provider's proffer of equitable reasons in support of an extension or reopening. *See St. Joseph's Hosp. of Kansas City*, 786 F.2d at 852 (observing that, in *Athens*, "the District of Columbia Circuit, while not specifically faced with the issue of whether the Board's refusal to hear an untimely appeal is a final decision, . . . endorsed the decision in *John Muir*," and agreeing that "section 1395oo(a) defines the limits of the Board's jurisdiction to render a final decision"); *Miami Gen. Hosp. v. Bowen*, 652 F. Supp. 812, 814 (S.D. Fla. 1986) ("42 U.S.C. § 1395oo provides for judicial review of [fiscal intermediary] determinations only where all of its procedural requisites have been met, among which is the requirement that a provider . . . file a request for hearing before the . . . [PRRB] within 180 days after . . . [the NPR] has been received"); *Arcadia Valley Hosp. v. Bowen*, 641 F. Supp. 190, 192 (E.D. Mo. 1986) ("Without meeting the 180 day time period of the statute, the Board . . . cannot issue a judicially reviewable final decision"); *Univ. of Chicago Hosp. & Clinics v. Heckler*, 605 F. Supp. 585, 586 (N.D. Ill. 1985). *But cf. Ozark Mountain Regional Rehabilitation Ctr. v. HHS*, 798 F. Supp. 16, 20 n.2 (D.D.C. 1992) (construing *Athens* as authorizing judicial review over appeals brought within the three-year period set forth at 42 C.F.R. § 405.1841(b)).

Plaintiffs contend that these cases are not applicable because they involve requests for a "good cause" extension of the 180-day limitations period in accordance with 42 C.F.R. § 405.1841, whereas plaintiffs never asked the Board for a "good cause" extension of the appeal period, instead requesting equitable tolling. *See* Pls.' Mem. at 19 n.8. But plaintiffs fail to recognize that, to the extent those cases discuss the law governing what is a "final decision" within the meaning of § 1395oo(f)—one of the main issues here—and do so in a manner that sheds light on the correct interpretation of *Athens*, they are, of course, relevant.

II. Equitable Tolling

Even if the PRRB decision is a "final decision" subject to judicial review under § 1395oo(f), plaintiffs may not obtain relief thereunder unless the statute authorizes "equitable tolling." Defendant contends that the explicit language of the statute shows that Congress intended to achieve finality by imposing a firm limitation on the time period within which payment determinations may be challenged. *See* Def.'s Mem. at 19-20. Defendant urges that equitable tolling therefore must be rejected here, just as it was rejected by the Supreme Court in the tax collection context in *United States v. Brockamp*, 519 U.S. 347 (1997). Defendant acknowledges that the Secretary has created an exception to the statutory time limit—the three year "good cause" extension authorized by 42 C.F.R. § 405.1841(b)—but contends that this exception is within the broad grant of rulemaking authority at 42 U.S.C. §§ 1302 and 1395hh and does not undercut defendant's position that no equitable tolling is otherwise allowed since it still imposes an outer limit of three years for administrative appeals, consistent with Congress's intent to achieve finality for payment calculations. *Id.* at 20. In defendant's view, plaintiffs' equitable tolling theory would effectively "extinguish" the time limitations on the handling of administrative claims. *Id.*

In response, plaintiffs contend that, under Supreme Court precedent, there is a presumption in favor of equitable tolling, relying primarily on *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), *Bowen v. City of New York*, 476 U.S. 468 (1986), and *Bradford Hosp. v. Shalala*, 108 F. Supp. 2d 473 (W.D. Pa. 2000). Plaintiffs view *Brockamp* as an outlier that was based on specific

statutory language and the uniqueness of the IRS taxpayer refund context at issue.

The starting point in determining whether equitable tolling is available under § 1395oo(f) is Congressional intent, rather than the applicability of one presumption or another. This is clear from the cases cited by both plaintiffs and defendant. *See Brockamp*, 519 U.S. at 350 (resolving the equitable tolling issue based on the standard: "Is there good reason to believe that Congress did *not* want the equitable tolling doctrine to apply?"); *City of New York*, 476 U.S. at 480 (examining whether application of equitable tolling to 60-day judicial review period is "consistent with the overall Congressional purpose" and is "nowhere eschewed by Congress"); *Irwin*, 498 U.S. at 95 (emphasizing importance of "greater fidelity to the intent of Congress" and application of a principle that is "a realistic assessment of legislative intent").

Irwin, however, offers little instruction on whether Congress intended equitable tolling to apply under a regime such as the Medicare program. *Irwin* was a Title VII case that considered whether the limitations period for filing a Title VII suit against the federal government was subject to equitable tolling, as it was for "private" employers. *See* 498 U.S. at 95. The Supreme Court held "that the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States." *Id.* at 95-96. Since then, *Irwin* has been interpreted as "announcing a 'general rule' establishing a presumption in favor of equitable tolling," but only where there is a "sufficiently similar" private suit that warrants application of such a presumption. *See Chung*

v. Dep't of Justice, 333 F.3d 273, 277 (D.C. Cir. 2003) (citing *Brockamp*, 519 U.S. at 350). Although the "similarity" inquiry is to be conducted "at a fairly high level of generality," *id.*, without the existence of equitable tolling in a "similar" suit against a private defendant—and none has been identified here, where the programmatic reimbursement at issue is not familiar to private litigation—there would be no presumption of equitable tolling.[10]

Nor does *City of New York* advance the analysis in any significant measure. There, the Supreme Court considered whether equitable tolling applied to the 60-day judicial review period for agency determinations as to Social Security "disability" status, and held that equitable tolling was available. But the language of the relevant statute, 42 U.S.C. § 405(g), was materially different. *See* 476 U.S. at 471-75. Section 405(g) provided for judicial review of an agency decision "within sixty days after the mailing to him of notice of such decision *or within such further time as the Secretary may allow*." 476 U.S. at 472 n.3 (emphasis added). That open-ended discretionary language—"within such further time as the Secretary may allow"—is altogether absent

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[10] For this reason, plaintiffs' reliance on *Bradford Hospital v. Shalala*, 108 F. Supp. 2d. 473 (W.D. Pa. 2000), does little to advance their argument. In finding equitable tolling available, the district court deemed the Medicare regulation at issue (42 C.F.R. § 412.328(f)) "more analogous to the Title VII limitation provision in 42 U.S.C. § 2000e-16," and hence applied *Irwin*'s presumption of equitable tolling, finding *Brockamp* inapposite. 108 F. Supp. 2d at 485. But that characterization is incorrect, for as discussed above, *Irwin* has little applicability to limitations periods in the Medicare context. In any event, the district court's assessment of 42 C.F.R. § 412.328(f) sheds no light on this Court's assessment of a separate statutory provision.

from the 180-day limitations period set forth in § 1395oo(a)(3).

Brockamp offers the most insightful guidance on discerning Congressional intent with respect to equitable tolling, indicating that in a complex regulatory regime, courts should focus on the language of the statute and the "nature of the underlying subject matter." 519 U.S. at 350-53. In *Brockamp*, the Supreme Court considered whether the limitations period for filing tax refund claims, 26 U.S.C. § 6511, was subject to equitable tolling, and held that "Congress did not intend the 'equitable tolling' doctrine to apply." *Id.* at 348, 354. The Court found significant that the statute expressed its time limitations in "unusually emphatic form," and "in a highly detailed technical manner, that, linguistically speaking, cannot easily be read as containing implicit exceptions."[11] *Id.* at 350-51. The Court also emphasized that the statute set forth "explicit exceptions to its basic time limits, and those very specific exceptions do not include 'equitable tolling.'" *Id.* at 351. The Court considered secondarily whether the "nature of the underlying subject matter"—tax collection—supported its conclusion that Congress did not intend for equitable tolling to apply. *Id.* at 352-53 ("The nature of the underlying subject matter . . . underscores the linguistic point."). Considering the sheer number of tax returns and tax refunds processed each year—200 million tax returns, and 90 million refunds—the Court found it reasonable to

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[11] Section 6511 states that a "[c]laim for . . . refund . . . of any tax . . . shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed . . . within 2 years from the time the tax was paid." 26 U.S.C. § 6511(a)

infer that Congress did not intend equitable tolling to apply. *Id.* ("The nature and potential magnitude of the administrative problem suggest that Congress decided to pay the price of occasional unfairness in individual cases . . . in order to maintain a more workable tax enforcement system.")

Applying these considerations here, the Court's assessment is that § 1395oo sets forth in "emphatic" language that the 180-day limitations period shall apply, albeit to a slightly lesser degree than does 26 U.S.C. § 6511. Section 1395oo(a)(3) states that a provider may obtain a Board hearing in enumerated scenarios "if"—

> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph 1(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

Section 1395oo also contains a provision concerning accumulation of interest that is tied to the 180-day limitations period:

> (f)(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section. . . .

42 U.S.C. § 1395oo(f)(2). As in the tax refund setting, moreover, the limitations provisions appear "in a highly detailed technical manner."

To be sure, the statutory language addressing the limitations period here is not as complex as that reviewed in *Brockamp*. Nonetheless, the language on its face bears no indicia that equitable tolling is intended, and the D.C. Circuit, in *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 620 (D.C. Cir. 1994), described the statutory language as demonstrating that, "[i]f a provider permits that deadline to lapse, the Statute envisions no further appeal of the intermediary's decision." That court further observed that allowing a provider to bypass the 180-day limitations period (in that case, by obtaining reopening more broadly than authorized by the reopening regulations) "'would frustrate the congressional purpose, *plainly evidenced in [the statute], to impose a [time] limitation upon . . . review.*'" *Id.* at 620 (quoting *Califano v. Sanders*, 430 U.S. 99, 108 (1977)) (alterations in original, emphasis added). Hence, under *HCA*, and this Court's own reading of § 1395oo(a)(3), the plain language of the statute indicates that Congress did not intend to authorize equitable tolling.

And there is more. As noted earlier, the Secretary has longstanding and comprehensive regulations governing extension of the administrative appeal period and also reopening of payment determinations by an intermediary or, in an appropriate case, the Board or Secretary. 42 C.F.R. §§ 405.1841(b), 405.1885. *Brockamp* did not have occasion to consider whether an agency's promulgation of rules that effectively extend or toll the time for seeking administrative relief would have affected its

analysis. But because those regulations were promulgated pursuant to the Secretary's statutory authority, and have been validated by the D.C. Circuit and the Supreme Court, they must weigh in this calculus.

The regulations governing extension of the administrative appeal period and reopening of old decisions are very detailed—comparable to the detailed timing provisions at issue in *Brockamp*. They generally establish three years as the outer limit for reopening where one of the showings enumerated in the regulation has been made, and like the provision reviewed in *Brockamp*, the time limitations are set forth in "unusually emphatic form," and "in a highly detailed technical manner, that, linguistically speaking, cannot easily be read as containing implicit exceptions." *See* 519 U.S. at 35-51. In particular, they provide, *inter alia*, that: "Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision. . . . No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section." 42 C.F.R. § 405.1885(a). The regulations also delineate the standard for determining when reopening will be mandatory, providing that a determination "must be reopened and revised by the intermediary if, within the three year period specified in paragraph (a) of this section, CMS . . . provides notice to the intermediary that the intermediary determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect. . . ." *Id.* § 405.1885(b). One circumstance where the three-year period shall not apply is identified—where "it is established that such determination or decision was procured by fraud or similar fault

of any party to the determination or decision." *Id.* § 405.1885(d) (emphasis added).

HCA Health Servs. held that the Secretary's reopening regulations fell "comfortably" within her rulemaking authority under 42 U.S.C. §§ 1302 and 1395hh. 27 F.3d at 618. More significantly, in rejecting a provider's argument that the reopening provisions should be read broadly, the court observed that "[p]erhaps the most convincing argument in favor of choosing the Secretary's reading over that urged by [the provider] is the preservation of the Medicare Statute's 180-day limitation on reviewing an intermediary's determination of total program reimbursement" as set forth in § 1395oo(a)(3). *Id.* at 620. Hence, the court rejected the provider's argument that all matters covered by an NPR can be reopened whenever any single issue in the NPR is reopened by the intermediary. *Id.* Here, the "preservation of the Medicare Statute's 180-day limitation period" would be entirely undercut by plaintiffs' broad proposition that equitable tolling is authorized by § 1395oo(a)(3). Indeed, the reopening regulations would be rendered virtually superfluous.

In *Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 453 (1999), the Supreme Court indicated that the plain language of the 180-day limitations period in § 1395oo(a)(3) demonstrated that judicial review of stale determinations was not allowed—there, under the mantel of an attempt to obtain judicial review of a reopening decision. The Court in *Your Home* considered whether the PRRB had jurisdiction to review a fiscal intermediary's refusal to reopen a reimbursement determination, and ultimately concluded that the Board—and hence the district court—did *not* have jurisdiction to

review a refusal to reopen. *Id.* at 453-55. In reaching this conclusion, the Court effectively upheld the reopening regulations in language strongly suggesting that the 180-day limitations period cannot be circumvented based on general fairness considerations:

> The right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180-day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395oo(a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely.
>
> . . .
>
> Title 42 CFR § 405.1885 (1997) generously gives them [providers] a second chance to get the decision changed—this time at the hands of the intermediary itself, but without the benefit of administrative review. That is a "suitable" procedure, especially in light of the traditional rule of administrative law that an agency's refusal to reopen a closed case is generally "'committed to agency discretion by law'" and therefore exempt from judicial review. . . . As for the alleged "double standard," given the administrative realities we would not be shocked by a system in which underpayments could *never* be the basis for reopening. . . . [E]ach of the tens of thousands of sophisticated Medicare-provider recipients of these NPRs is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. § 1395oo(a)(3).

525 U.S. at 454-56 (emphasis in original, citations omitted). The Supreme Court's assessment of § 405.1885 strongly indicates that the 180-day limitations period is not subject to equitable tolling. Based on the statutory

language, the regulations granting only limited exceptions to the 180-day limitations period, and the Supreme Court's determination in *Your Home* that the 180-day limit may not be circumvented by expanding Board (and hence, district court) jurisdiction to review requests to reopen, the Court concludes that equitable tolling of the 180-day limitations period is not available under 42 U.S.C. § 1395oo.

Brockamp suggests that the Court may consider, albeit secondarily, whether "the nature of the underlying subject matter" supports the Court's assessment of the statutory language. *See* 519 U.S. at 352 ("The nature of the underlying subject matter—tax collection—underscores the linguistic point."). Hence, defendant submits an array of statistics to demonstrate that the complexity of the Medicare program and the administrative burden of allowing equitable tolling under § 1395oo(a) confirm the unreasonableness of construing the statute to authorize equitable tolling.[12] *See* Def.'s Mem. at 21-22. The Court declines to rely specifically on that extra-pleading information here because the viability of most of plaintiffs' claims is being challenged on a motion to dismiss under Rule 12(b)(6), rather than on summary judgment. However, the Court notes the Supreme Court's observation in *Your Home* that "tens of

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[12] For example, defendant asserts that "[t]he Medicare program involves nearly $212 billion in annual payments to over 38,000 providers" as well as other entities, that it processes "more than a billion claims per year," and that 25 contractors process $202 billion in claims for about 6,000 hospitals, 15,000 skilled nursing facilities, and other providers of institutional care under Medicare Part A." *See* Def.'s Mem. at 21-22 (citing http://www.cms.hhs.gov/CapMarketUpdates/Downloads/2007CMSstat.pdf). Although plaintiffs do not dispute these figures, they are technically beyond the scope of a Rule 12(b)(6) motion.

thousands of sophisticated Medicare-providers" are recipients of NPRs, and its corresponding assessment that, hence, "administrative realities" may result in underpayments that are never reopened. 525 U.S. at 456. The volume and complexity of the provider reimbursement program at issue here is, quite plainly, comparable to the tax refund program in *Brockamp*, as to which the Supreme Court observed that the "magnitude of the administrative problem" cut against the availability of equitable tolling. To this extent, then, the complexity and nature of the Medicare Part A program supports the Court's conclusion that Congress did not intend to authorize equitable tolling in § 1395oo(a). In any event, plaintiffs have proffered nothing suggesting that the nature of the Medicare program implies that Congress intended to authorize equitable tolling for provider claims, notwithstanding the express language of § 1395oo(a) and the longstanding regulations granting only limited relief from the 180-day limitations period. Hence, although not central to this Court's analysis, the Court's determination that equitable tolling is not authorized by §1395oo(a) is buttressed by the scope and complexity of the Medicare program.

III. Mandamus

Plaintiffs contend that, in the event they are precluded from obtaining relief under § 1395oo(f), they are entitled to a writ of mandamus requiring new DSH determinations under 28 U.S.C. § 1361 because defendant has a "non-discretionary duty to use correct SSI percentages" when determining DSH payments. *See* Pls.' Mem. at 20-22. Plaintiffs further assert that defendant has a nondiscretionary duty to reopen intermediary determinations "if it is established that such determination

. . . was procured by fraud or similar fault of any party to the determination or decision"—a point they consider established by the *Baystate* decisions issued by the Board and this Court. Pls.' Mem. at 12, 21 (quoting 42 C.F.R. § 405.1885(d)). Defendant counters that the Court lacks mandamus jurisdiction because plaintiffs fail to satisfy the prerequisites for mandamus relief. *See* Def.'s Mem. at 12-18; Def.'s Reply at 8-9. The relevant duty for the mandamus inquiry, in defendant's view, is whether the Secretary had a nondiscretionary duty to extend the 180-day limitations period or to reopen the NPR. Under the regulations, both of those matters are plainly discretionary, which would preclude mandamus relief. Defendant further contends that plaintiffs' failure to exhaust administrative remedies precludes them from obtaining mandamus relief.

Mandamus is a drastic remedy to be invoked only in extraordinary situations and to be granted only when essential to the interests of justice. *See Oglala Sioux Tribe of Pine Ridge Indian Reservation v. U.S. Army Corps of Eng'rs*, 570 F.3d 327, 333 (D.C. Cir. 2009). Under 28 U.S.C. § 1361,[13] a court has jurisdiction to grant mandamus relief only if "(1) the plaintiff has a clear right to relief; (2) the defendant has a clear duty to act; and (3) there is no other adequate remedy available to plaintiff." *In re Medicare Reimbursement Litig.*, 414 F.3d at 10 (quoting *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002)); *Fornaro v. James*, 416 F.3d 63, 69 (D.C. Cir. 2005). To maintain a mandamus action

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[13] The mandamus statute provides that "[t]he district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." 28 U.S.C. § 1361.

in the Medicare context, a plaintiff also must exhaust his administrative remedies unless exhaustion would be futile. *Heckler v. Ringer*, 466 U.S. 602, 616-18 (1984); *Monmouth Med. Ctr.*, 257 F.3d at 813. "[I]f there is no clear and compelling duty under the statute as interpreted, the district court must dismiss the action." *In re Cheney*, 406 F.3d at 729. The party seeking mandamus has the "burden of showing that [his] right to issuance of the writ is clear and indisputable." *Gulfstream Aerospace Corp v. Mayacamas Corp.*, 485 U.S. 271, 289 (1988) (internal quotation marks and citation omitted).

The parties focus primarily on whether defendant owes plaintiffs a nondiscretionary duty, but identification of the relevant duty has shifted as the litigation has developed. Plaintiffs' complaint alleges that the nondiscretionary duty owed to providers is a "nondiscretionary duty to use correct SSI percentages" when determining DSH payments. Compl. ¶¶ 62, 64; *see* Pls.' Mem. at 20. In their merits brief and at the motions hearing, however, plaintiffs rely almost exclusively on defendant's duty to reopen and revise a determination whenever "fraud or similar fault of any party" is established. *See* Pl.'s Mem. at 21-22 (quoting 42 C.F.R. § 405.1885(d)).

Plaintiffs fail to establish a nondiscretionary duty to act in either formulation. With respect to the so-called "duty to use correct SSI percentages" in determining DSH payments, plaintiffs misconstrue the case law. This Court has previously held that the "best available data" standard, long-recognized in the case law as governing other Medicare reimbursement determinations, governs the validity of SSI percentages, not some abstract standard of "correctness" or perfection. *See*

Baystate, 545 F. Supp. 2d at 49 ("The case law amply supports the proposition that the best available data standard leaves room for error, so long as more reliable data did not exist at the time of the agency decision.") (citing *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1228-30 (D.C. Cir. 1994), and *Mt. Diablo Hosp. v. Shalala*, 3 F.3d 1226, 1233 (9th Cir. 1993)).

Even recasting plaintiff's "duty" argument as a duty to determine the SSI percentages based on the "best available data," plaintiffs would not succeed. The failure to use the "best available data"—or to use "correct" SSI percentages for that matter—is, in essence, an allegation that the intermediary's determination was "inconsistent with the applicable law." The regulations require reopening of an NPR in this circumstance only where "CMS . . . [p]rovides notice to the intermediary that the intermediary determination . . . is inconsistent with the applicable law, regulations, CMS rulings, or CMS general instructions in effect, and as CMS understood those legal provisions at the time the determination or decision was rendered by the intermediary." 42 C.F.R. § 405.1885(b)(1)(i). As defendant points out, "CMS has never explicitly (or implicitly) notified plaintiffs' intermediaries that their determinations were inconsistent with applicable law," and, indeed, defendant's position is that those determinations involve, at worst, a "flawed data" problem, not any inconsistency with the law.[14] *See* Def.'s Mem. at 14-15. In the absence of CMS

[14] Even if this Court's *Baystate* decision operated as a *de facto* notice of inconsistency with applicable law, § 405.1885(b)(1)(i) would not impose a duty on CMS or the intermediaries to reopen the NPRs at issue. This is because, with respect to inconsistency with applicable law, the regulation imposes a duty to reopen only if the notice of inconsistency occurs "within the three-year period" after the date of the

issuing a notice to the intermediary stating that the determination is inconsistent with applicable law, there is no mandatory duty to reopen a payment determination.

Plaintiffs' main contention, in any event, is that they are entitled to mandamus relief based on defendant's duty to reopen payment determinations procured by fraud. *See* Pl.'s Mem. at 21- 22 (discussing 42 C.F.R. § 405.1885(d)). In their view, the *Baystate* decisions issued by the Board in 2006 and this Court in 2008 establish that the data flaws underlying their NPRs were "deliberately concealed" by CMS, which requires reopening under the fraud provision "at any time." *Id.* at 22. There are two problems with this argument. First, nothing in either of the *Baystate* decisions reflects a finding that CMS "deliberately concealed" the data flaws at issue or otherwise engaged in fraud. Rather, the Board simply found that "'that CMS knew or should have known at least by 1993 that there was a problem with the SSI data received from SSA,'" and thus rejected the contention that CMS had used the "best available data." *Baystate*, 545 F. Supp. 2d at 27 (quoting *Baystate* Board Decision at 34-35). The Board made no finding regarding fraud or deliberate concealment. This Court, reviewing the Board's decision, similarly concluded that CMS had not used the "best available data," but likewise made no finding regarding fraud or deliberate concealment. *Id.*

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intermediary's determination (i.e., NPR issuance), effectively excluding NPRs older than three years from the mandatory reopening. *See Baptist Mem. Hosp. v. Johnson*, 603 F. Supp. 2d 40, 43-44 (D.D.C. 2009). Here, plaintiffs' NPRs were issued far outside of that three-year window, with the most recent having been issued in or around 1996.

Second, and equally significant, plaintiffs have failed to exhaust their administrative remedies. As noted earlier, exhaustion of administrative remedies is a prerequisite to the extraordinary remedy of mandamus, unless exhaustion would be futile. *See Monmouth*, 257 F.3d at 810 ("we must first examine all other possible avenues of relief to ensure that the hospitals have fully exhausted those which were available"); *In re Medicare Reimbursement Litig.*, 414 F.3d at 11 (finding that futility was demonstrated where, *inter alia*, the reopening period had expired and CMS had issued a ruling "barr[ing] intermediaries from reopening closed NPRs to recalculate DSH entitlement"). Indeed, where providers seek mandamus based on the reopening provisions, they must show that "they have done all they can to vindicate their right to reopening." *Monmouth*, 257 F.3d at 815.

There is no allegation in the complaint that plaintiffs ever sought to reopen their NPRs based on fraud, and they admitted as much at the motions hearing. Their only excuse is that they anticipate difficulties in obtaining information from the agency to support their claim of fraud. But by plaintiffs' own account, they believe evidence in the Board's *Baystate* administrative record supports their allegations of fraud, and that record was long-ago filed with this Court in the *Baystate* civil action. *See Baystate Med. Ctr. v. Leavitt*, Civil Action No. 06-1263, Notice of Filing of Administrative Record (D.D.C. filed Nov. 22, 2006). Moreover, plaintiffs have other means for obtaining information in support of their claim, such as the Freedom of Information Act. Plaintiffs suggested at the motions hearing that, even if they obtain evidence demonstrating fraud, a request for reopening is likely to be unsuccessful, and defendant's

litigation counsel suggested the same.[15] But as was observed recently in *Bradley Mem. Hosp. v. Leavitt*, 599 F. Supp. 2d 6, 17 (D.D.C. 2009), "[t]he point of pursuing administrative relief is to exhaust avenues by which [p]laintiffs might have convinced the agency to change its position without resorting to the type of extraordinary relief that [p]laintiffs now request." In short, there is no basis here for excusing plaintiffs from the requirement to exhaust administrative remedies as a prerequisite to mandamus relief.

Should plaintiffs exhaust their administrative remedies, and then return to court with evidence that establishes fraud or concealment with respect to the calculation of the SSI percentages, a court may consider their request for mandamus relief anew. But at this time, plaintiffs have fallen far short of alleging facts that would establish their entitlement to the extraordinary remedy of mandamus.[16]

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[15] At the motions hearing, a Department of Justice attorney suggested for the first time during rebuttal argument that the fraud reopening provision is not applicable if the person allegedly acting fraudulently is the Secretary because the Secretary is not a "party" to the intermediary's determination within the meaning of the regulation. This contradicts defendant's earlier statement in its brief that plaintiffs should be required to exhaust their administrative remedies with respect to the allegation of fraud under § 405.1885(d). *See* Def.'s Reply at 9 n.5. Because the attorney presenting rebuttal offered only a post hoc interpretation of the regulation that is inconsistent with the brief approved by the agency, the Court gives the statement no weight.

[16] In Count Three of the complaint, plaintiffs seek substantially the same mandamus relief under the All Writs Act, 28 U.S.C. § 1651(a). *See* Compl. ¶¶ 63-64. It is well-settled, however, that "the Act itself is not a grant of jurisdiction." *In re Tennant*, 359 F.3d 523, 527 (D.C. Cir. 2004). The All Writs Act provides that the federal courts "may issue all writs necessary or appropriate *in aid of* their respective

IV. Availability of Relief under 28 U.S.C. § 1331

As a last resort, plaintiffs invoke the federal question statute, 28 U.S.C. § 1331, as a basis for bringing their claims for relief. Plaintiffs contend that if judicial review of their challenges is not available under § 1395oo(f) or the mandamus statute, they are entitled to bring their claims for relief directly under § 1331. Defendant responds that Congress has disallowed judicial review of Medicare claims under § 1331, as set forth in 42 U.S.C. § 405(h) and § 1395ii, instead choosing to channel judicial review under § 1395oo. The Court agrees.

As the D.C. Circuit explained in *Monmouth*, § 1395oo sets forth "detailed instructions on the means for seeking review of payment determinations," and in tandem with that provision, "[§] 1395ii generally forecloses other avenues of review by incorporating the review-limiting provisions of the Social Security Act, 42 U.S.C. § 405(h)." 257 F.3d at 809. Section 405(h), with the substitutions required by § 1395ii, provides that:

> The findings and decision of [the Secretary of HHS] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of [the Secretary of HHS] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against

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jurisdictions and agreeable to the usages and principles of law." 28 U.S.C. § 1651(a) (emphasis added). This statutory language makes clear that the authority to issue writs is confined to the issuance of process "in aid of" jurisdiction that is created by some other source and not otherwise enlarged by the Act. *In re Tennant*, 359 F.3d at 527. Because the All Writs Act does not provide a separate basis for relief, Count Three will be dismissed.

> the United States, the [Secretary of HHS], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

Monmouth, 257 F.3d at 809 (quoting 42 U.S.C. § 405(h), alterations in original).[17] Hence, § 1331 "review [of Medicare payment determinations] could not be more plainly off limits under 42 U.S.C. § 405(h), which explicitly withholds § 1331 jurisdiction for 'any claim arising under this title.' " *Id.* at 812. A provider's claim "arise[s] under" the Medicare Act within the meaning of § 405(h) when "'both the standing and the substantive basis for the presentation of the claim are the Medicare Act.'" *Your Home*, 525 U.S. at 456 (quoting *Ringer*, 466 U.S. at 615). Here, plaintiffs' claims clearly arise under the Medicare Act—and hence are covered by § 405(h)—because they arise from the calculation of payments under the Medicare DSH provision and have as their ultimate goal the recovery of additional sums under the Medicare Act. *See Monmouth*, 257 F.3d at 812.

To be sure, the Supreme Court has recognized a narrow exception to § 405(h) where its application "would not simply channel review through the agency, but would mean no review at all." *See Shalala v. Illinois Council on Long Term Care*, 529 U.S. 1, 19 (2000). Plaintiffs contend that they fall within this exception

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[17] Section 1395ii provides that "[t]he provisions . . . of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in applying such provisions with respect to this subchapter [Medicare], any reference therein to the Commissioner of the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively."

because, without judicial review of their DSH payments under § 1331, the Secretary's actions would be immunized from judicial scrutiny. *See* Pls.' Mem. at 22. The flaw in plaintiffs' position, however, is that judicial review of plaintiffs' DSH payments was, in fact, available under § 1395oo(f), but plaintiffs missed their opportunity to obtain judicial review by failing to seek Board review within 180 days of receiving the intermediary's final determination. Hence, it is only by virtue of plaintiffs' untimeliness that judicial review on their current claims may be foreclosed. The Secretary's actions in implementing the DSH program have *not* generally been immunized from judicial review, then, as demonstrated by cases before this Court in which providers did, in fact, file timely administrative appeals raising the same issues as plaintiffs, as well as cases under § 1395oo. *See, e.g., Baystate*, 545 F. Supp. 2d 20; *Northeast Hosp. Corp. v. Sebelius*, Civil Action No. 09-0180 (D.D.C. filed Jan. 30, 2009).[18] Moreover, to the extent that plaintiffs can identify a nondiscretionary duty owed to them under the Medicare Act, they may obtain judicial review and relief under the mandamus statute—an avenue left open by this Court's resolution of the mandamus claim. As with any claim for relief, the failure of plaintiff to seek judicial review in a timely manner, or to prevail on a claim, does not mean that there is, under *Illinois Council*, "no review at all." Accordingly, pursuant to § 1395ii and § 405(h), the Court concludes that it

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[18] In *Northeast Hosp.*, the Secretary has conceded that a provider who filed a timely appeal contesting its DSH payment based on the defects described in *Baystate* (and raised by plaintiffs in this case) was entitled to a remand for recalculation of its DSH payment. *See Northeast Hosp.*, Def.'s Mem. in Supp. of Mot. for Summ. J. at 5-6 (filed Oct. 2, 2009).

lacks jurisdiction to review plaintiffs' claims for relief directly under § 1331.

CONCLUSION

For the foregoing reasons, the Court will grant defendant's motion to dismiss. Plaintiffs' claims for relief under 42 U.S.C. § 1395oo and in the nature of mandamus will be dismissed for failure to state a claim upon which relief can be granted. Plaintiffs' claims for relief directly under 28 U.S.C. § 1331 will be dismissed for lack of subject matter jurisdiction. A separate order has been issued on this date.

/s/ JOHN D. BATES
JOHN D. BATES
United States District Judge

Dated: Mar. 11, 2010

APPENDIX C

[SEAL OMITTED]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 06-2359G [Received: Sept. 18, 2007]

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RE: UHS 87-94 DSH/SSI Equitable Tolling Grp
Provider Nos. Varopis
FYE 1987-1994
PRRB Case No. 06-2359G

Dear Mr. Roth and Ms. Uzzle:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional briefs of the parties in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Procedural History

The Providers filed this appeal on September 12, 2006 for the fiscal years (FYs) 1987-1993. There is no dispute regarding the fact that the Notices of Program Reimbursement (NPRs) for the fiscal years under dispute were all issued more than three years before the current request for hearing was filed. The Providers have requested that the Board consider whether the appeal is timely filed under the doctrine of equitable tolling over the issue under dispute: whether the Intermediary used an understated Supplemental Security Income (SSI) percentage when calculating the disproportionate share (DSH) adjustment.

Positions of the Parties

The Providers observe that the Centers for Medicare & Medicaid Services (CMS) calculates the SSI percentage but does not and believes its cannot share the data with providers. Further, the Claims Processing Manual (CMS Pub. 100-04) requires that intermediaries calculate the DSH adjustment using the SSI percentage fur-

nished to them by CMS. The Providers point to the decision in *Loma Linda Hospital v. Shalala*[1] to support its position that CMS will not release SSI data. The Board's decision in *Baystate Medical Center v. Mutual of Omaha*[2] (*Baystate*) is cited for the proposition that the SSI percentage is understated.

The Providers explained in their hearing request that their failure to file a timely appeal was the result of CMS' alleged knowing and unlawful refusal to inform hospitals that the SSI percentage was incorrectly stated for the fiscal years under appeal. Under 42 C.F.R. § 405.1841(b), the Board has the authority to extend the time for filing an appeal for up to three years from the issuance of the NPR based on "good cause." Good cause for late filing cannot be considered in these cases because the cases are being filed more than three years after the issuance of the NPRs for the FYEs in question. Consequently, the Providers are requesting that the Board apply the principle of equitable tolling and find that the appeal is timely.

The decision in *Bradford Hospital v. Shalala*[3] is cited for the proposition that equitable tolling is proper "when the principles of equity would make the rigid application of a limitation period unfair." In addition, *Irwin v. Veterans Administration*[4] (*Irwin*) is cited for the proposition that equitable tolling applies "where the complain-

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[1] 907 F. Supp. 1399 (C.D. Calif. 1995)

[2] PRRB Dec. 2006-D20 (March 17, 2006) (Medicare & Medicaid Guide (CCH)), ¶ 81,468; modified CMS Administrator's Dec. May 11, 2006 (Medicare & Medicaid Guide (CCH)) ¶ 81,506.

[3] 108 F. Supp. 2d 473 (W.D. Pa. 2000)

[4] 498 U.S. 89, 96 (1990)

ant has been induced or tricked by his adversary's misconduct into allowing the filing deadline to pass." The Providers assert that its failure to file on time was the direct result of CMS' failure to inform providers that the SSI percentages were understated for the FYEs under appeal. The Providers' believe that the Board's decision in *Baystate* establishes the fact that the SSI percentage is understated.

The Intermediary asserts that the Board lacks jurisdiction over the appeal because the NPRs were issued more than three years before the appeal was filed; therefore, the Board cannot consider good cause for late filing. Further, the Providers cannot establish that there was misconduct on the part of the other party which would make *Irwin* applicable. In addition, the Providers cannot prove that they were "induced or tricked" into missing appeal deadlines. There was no evidence in the *Baystate* decision that CMS knew 20 years ago that there was any defect in the SSI data. The Intermediary believes that the doctrine of equitable tolling is not appropriate here because the Providers are simply trying to take advantage of the favorable decision in *Baystate*.

The Intermediary points out that in *Anaheim Memorial Hospital v. Blue Cross of California*[5] (*Anaheim*) the Board found that it lacks the general equitable powers necessary to consider equitable tolling. The decision in *Bradford* can be distinguished from the current case because it dealt with the filing for a redetermination of the provider's hospital specific rate which is different from the timely filing of appeals. Finally, the Interme-

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[5] PRRB Dec. 2000-D72 (Medicare and Medicaid Guide (CCH)) ¶ 80,257.

diary points out that the statute of limitations for considering good cause is a statute of repose because it sets the final period of time for an appeal to be filed. The purpose is "to relieve potential defendants from anxiety and liability over acts committed long ago."

Decision of the Board

The Board finds that it lacks jurisdiction over the Providers' appeal of the fiscal years 1987-1993 because the appeal was not timely filed.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 and 405.1841, a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $50,000 or more for a group appeal and the request for hearing is filed within 180 days of the date of the final determination. Pursuant to 42 C.F.R. § 405.1841(b) the Board may consider a request for good cause for late filing if such a request was made within three years after the date the notice of intermediary determination is mailed to the provider. In this case, there is no dispute that the request for hearing was not made within three years of the issuance of the NPRs and good cause cannot be considered.

Further, consistent with the decision in *Anaheim*, the Board concludes that it does not have general equitable powers and cannot grant equitable relief such as equitable tolling. The Board is an administrative forum and, unlike the courts, does not have general equitable powers but rather only the powers granted to it by statute and regulation. The equitable powers granted to the

Board are found in 42 C.F.R. §§ 405.1841(b) (good cause) and 405.1885 (reopenings).

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Suzanne Cochran, Esq.
Elaine Crews Powell, CPA
Anjali Mulchandani-West, CPA
Yvette C. Hayes

FOR THE BOARD:

/s/ SUZANNE COCHRAN
SUZANNE COCHRAN, Esq.
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: George Porette, National Government Services (NY)
Wilson Leong, BCBSA

APPENDIX D

[LOGO OMITTED]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-20
Baltimore, Maryland 21244-1850
Telephone 410-786-3176 Facsimile 410-786-0043

[Received: Nov. 1, 2007]

Office of the Attorney Advisor

VIA FACSIMILE AND
FIRST CLASS MAIL

Robert L. Roth, Esquire
Crowell & Moring LLP
1001 Pennsylvania Avenue, NW
Washington, DC 2004-2595

Re: Hackensack University Medical Center, PRRB Case No. 06-2296; Crowell & Moring 87-93 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2357G; UHS 87-94 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2359G; Franklin Hospital Medical Center, PRRB Case No. 06-2355; Long Island Jewish Medical Center, PRRB Case No. 06-2352; North Shore University Hospital, PRRB Case No. 06-2354; Southside Hospital, PRRB Case No. 06-2356

Dear Mr. Roth:

This is to advise that the Administrator of the Centers for Medicare & Medicaid Services (CMS) has declined to review the decision entered by the Provider Reimbursement Review Board in the captioned case.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Board's decision was received in accordance with 42 CFR 405.1877.

Sincerely yours,

JACQUELINE R. VAUGHN
JACQUELINE R. VAUGHN
Attorney Advisor

Enclosure

cc: Ms. Linda Uzzle, Intermediary's Representative

[LOGO OMITTED]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-20
Baltimore, Maryland 21244-1850
Phone 410-786-3176 Facsimile 410-786-0043

Office of the Attorney Advisor

Re: Hackensack University Medical Center, PRRB Case No. 06-2296; Crowell & Moring 87-93 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2357G; UHS 87-94 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2359G; Franklin Hospital Medical Center, PRRB Case No. 06-2355; Long Island Jewish Medical Center, PRRB Case No. 06-2352; North Shore University Hospital, PRRB Case No. 06-2354; Southside Hospital, PRRB Case No. 06-2356

Pursuant to 42 CFR 405.1875(d)(2), I recommend that the Administrator, Centers for Medicare & Medicaid Services, decline to review the decisions entered by the Provider Reimbursement Review Board in these cases.

/s/ JACQUELINE R. VAUGHN
JACQUELINE R. VAUGHN
Attorney Advisor

APPROVED:

Date: [10/26/07]

/s/ HERB B. KUHN
HERB B. KUHN
Deputy Administrator
Centers for Medicare &
Medicaid Services

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115
September Term 2011
1:07-cv-02075-JDB

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
APPELLANTS

v.

KATHLEEN SEBELIUS, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEE

Filed: Dec. 20, 2011

ORDER

Before: HENDERSON and GRIFFITH*, Circuit Judges, and WILLIAMS*, Senior Circuit Judge

Upon consideration of appellee's petition for panel rehearing filed August 8, 2011, it is

---

* Circuit Judge Griffith and Senior Circuit Judge Williams vote to deny the petition for the reasons set forth in their statement concurring in the denial of appellee's petition for rehearing en banc filed December 20, 2011.

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/ MICHAEL C. McGRAIL
MICHAEL C. MCGRAIL
Deputy Clerk

APPENDIX F

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115
September Term 2011
1:07-cv-02075-JDB

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
APPELLANTS

v.

KATHLEEN SEBELIUS, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEE

Filed: Dec. 20, 2011

ORDER

Before: SENTELLE, Chief Judge, and HENDERSON, ROGERS, TATEL, GARLAND, BROWN, GRIFFITH*, and KAVANAUGH, Circuit Judges, and WILLIAMS*, Senior Circuit Judge

---

* A statement by Circuit Judge Griffith, joined by Senior Circuit Judge Williams, concurring in the denial of rehearing en banc is attached.

Upon consideration of appellee's petition for rehearing en banc, the response thereto, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/ MICHAEL C. McGRAIL
MICHAEL C. MCGRAIL
Deputy Clerk

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115
September Term 2011

Griffith, Circuit Judge, joined by Williams, Senior Circuit Judge, concurring in the denial of rehearing en banc: The Secretary urges the reconsideration of our conclusion that Congress did not preclude equitable tolling of the limitations period for filing Medicare reimbursement claims on the ground that we overlooked the administrative burdens that tolling brings. But we were simply following the analytical framework set forth in *United States v. Brockamp*, 519 U.S. 347 (1997). Panel Op. 7-10. The Supreme Court undertook the inquiry in two stages. Looking first at the limitations provisions of the statute, the Court concluded that the statute's "detail, its technical language, the iteration of the limitations in both procedural and substantive forms, and the explicit listing of exceptions," taken together, showed that Congress did not intend other equitable exceptions to be read into the statute. *Brockamp*, 519 U.S. at 352. The burdens caused by equitable tolling, the second stage in the Court's analysis, simply underscored what an analysis of the text had already revealed. As we read *Brockamp*, we need not look at any burdens that might flow from equitable tolling when the textual factors fail to rebut the presumption. We can imagine their relevance when the text of the statute is not otherwise clear, but in this case the statute itself is without any clues that suggest Congress barred equitable tolling.

It is unclear whether *Holland v. Florida*, 130 S. Ct. 2549 (2010), transformed *Brockamp*'s two-step approach

into a balancing test that puts administrative burdens on an equal footing with the textual factors. In *Holland*, the Supreme Court included the administrative burdens that might result from equitable tolling alongside the textual factors the Court used in *Brockamp* to conclude that the limitations period in the Antiterrorism and Effective Death Penalty Act of 1996 may be equitably tolled. *See id.* at 2561. We need not decide whether this marks a change in the Court's analysis because even if the burdens created by equitable tolling are now an indispensable part of the inquiry, they do not change the outcome in this case. None of the textual factors in the Medicare reimbursement statute weigh in favor of equitable tolling. Unlike the emphatic, detailed, and repeated limitations provisions in *Brockamp*, the limitations provision here is simple and includes no exceptions that suggest Congress intended to preclude equitable tolling. *See* Panel Op. 7-8. While allowing equitable tolling may increase the amount of interest recoverable, that effect is straightforward relative to the potential effect of tolling in *Brockamp*, where the calculation of the refund itself changed depending on when claims were filed. *See Brockamp*, 519 U.S. at 351. Although it is no doubt true that the complex Medicare reimbursement scheme will be more difficult to administer with equitable tolling available to claimants, that factor alone is not enough to persuade us that Congress rejected the presumption of equitable tolling with the type of clarity the precedents require.

Accordingly, we concur in the denial of rehearing en banc.

APPENDIX G

1. 42 U.S.C. 405(a) provides:

Evidence, procedure, and certification for payments

(a) Rules and regulations; procedures

The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

2. 42 U.S.C. 1302(a) provides:

Rules and regulations; impact analyses of Medicare and Medicaid rules and regulations on small rural hospitals

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

3. 42 U.S.C. 1395hh(a)(1) provides:

Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

4. 42 U.S.C. 1395ww(d)(5) provides in pertinent part:

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

* * * * *

(F)(i) For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

* * * * *

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage

(as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such

hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

* * * * *

5. 42 U.S.C. 1395*oo* provides:

Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to

the Secretary with respect to subchapter II of this chapter.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board re-

ceives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of de-

termining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

6. 42 C.F.R. 405.1836 provides:

Good cause extension of time limit for requesting a Board hearing.

(a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

(b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

(c) The Board may not grant a request for an extension under this section if—

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the Board must give prompt written notice to the provider, and mail a copy of the notice to each party to the appeal. The notice must include a detailed explanation of the reasons for the decision by the Board and the facts underlying the decision.

(e)(1) If the Board denies an extension request and determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Board dismissal decision dismissing the appeal for lack of Board jurisdiction. This decision by the Board must be in writing and include the explanation of the extension request denial required under paragraph (d) of this section, in addition to specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal (as described in §405.1840(c) of this subpart). A copy of the Board's dismissal decision must be mailed promptly to each party to the appeal (as described in § 405.1843 of this subpart).

(2) A Board dismissal decision under paragraph (e)(1) of this section is final and binding on the parties, unless the decision is reversed, affirmed, modfied, or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) This Board decision is inoperative during the 60-day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision, within the period.

(ii) A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened and revised by the Board in accordance with § 405.1885 through § 405.1889 of this subpart.

(3) The Administrator may review a Board decision granting an extension request solely during the course of an Administrator review of one of the Board decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2) of this subpart.

(4) A finding by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time for requesting a Board hearing is not subject to judicial review.

7. 42 C.F.R. 405.1841 (2007) provides:

Time, place, form, and content of request for Board hearing.

(a) *General requirements.*

(1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see § 413.17 of this chapter) must be brought by the providers as a group appeal (see § 405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or CMS Rulings common to the providers and for which the amount in controversy is $50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently

with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

8. 42 C.F.R. 405.1885 (2007) provides:

Reopening a determination or decision.

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year pe-

riod except as provided in paragraphs (d) and (e) of this section.

(b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3-year period specified in paragraph (a) of this section, CMS—

(i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and

(ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.

(2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

(3) Notwithstanding paragraph (b)(1)(i) of this section, CMS may direct the intermediary to reopen a particular intermediary determination or intermediary hearing decision in order to implement, for the same intermediary determination or intermediary decision—

(i) A final agency decision under §§ 405.1833, 405.1871(b), 405.1875, or 405.1877(a) of this part;

(ii) A final nonappealable court judgment; or

(iii) An agreement to settle an administrative appeal or a lawsuit.

(c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.

(e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

(f) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c).) However, the 3-year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27, 1972 (the effective date of regulations which, prior to the publication of this Subpart R, governed the reopening of such determinations).

OPPOSITION BRIEF

RECORD
AND
BRIEFS

Supreme Court U.S.
FILED
MAY 14 2012
OFFICE OF THE CLERK

No. 11-1231

IN THE

Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the D.C. Circuit correctly applied this Court's precedents concerning the presumptive availability of equitable tolling to the statutory limitations period governing challenges to Medicare program payments for hospital services.

RULE 29.6 STATEMENT

Respondents are the public or private non-profit organizations identified below along with their parent entities.

Group I	
Hospital Name	**Parent Corporation**
Doctors Hospital of Staten Island (merged into Staten Island University Hospital)	North Shore – Long Island Jewish Health System
Forest Hills Hospital	North Shore – Long Island Jewish Health System
Franklin Hospital	North Shore – Long Island Jewish Health System
Hackensack University Medical Center	Hillcrest Health Service System, Inc.
Long Island Jewish Medical Center	North Shore – Long Island Jewish Health System
Staten Island University Hospital	North Shore – Long Island Jewish Health System
Southside Hospital	North Shore – Long Island Jewish Health System

Group II	
Hospital Name	**Parent Corporation is Publicly-Traded Company**
Auburn Regional Medical Center	Universal Health Services, Inc.
Chalmette Medical Center	Universal Health Services, Inc.
Edinburg Regional Medical Center	Universal Health Services, Inc.
Inland Valley Regional Medical Center	Universal Health Services, Inc.
McAllen Medical Center	Universal Health Services, Inc.
Northern Nevada Medical Center	Universal Health Services, Inc.
River Parishes Hospital	Universal Health Services, Inc.
UHS of New Orleans	Universal Health Services, Inc.
Universal Health Services, Inc.	None
Wellington Regional Medical Center	Universal Health Services, Inc.

Group III	
Hospital Name	**Publicly-Traded Companies that have 10 Percent or More Ownership Interest**
Valley Hospital Medical Center	Universal Health Services, Inc. and Community Health Systems, Inc.

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INTRODUCTION

The petition for certiorari filed on behalf of the Secretary of Health and Human Services (the "Secretary") arises in the context of the Respondent hospitals' ("the Hospitals'") efforts to obtain payment statutorily due for services provided to patients under the Medicare program. The petition presents no issue of moment justifying this Court's intervention, reflecting a straightforward application of this Court's precedents holding that principles of equitable tolling are presumptively applicable to federal limitations periods. The Secretary does not, of course, challenge those precedents. But they are, in truth, the ultimate source of the Secretary's unhappiness, because those precedents potentially preserve a claimant's right to be paid what the Government owes where the claimant "has been induced or tricked by [the Government's] misconduct into allowing the filing deadline to pass." *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 96 (1996).

The decision of the court below does little more than reaffirm the general principles announced by this Court on the presumptive availability of equitable tolling in connection with any federal statutory limitations period, and then apply them comfortably to the statutory limitations period at issue. The Secretary offers no textual basis to suggest that equitable tolling does not apply in the context of a provider's effort to recover what is owed for services rendered under the Medicare program. The Secretary concedes that there is no directly contrary precedent on the issue. The Secretary's labored effort to manufacture a "conflict" among the Circuits on some conceptual basis is, at best, illogical but, in any event, stale. And the suggestion that

even in the absence of some textual (or historical) basis for overcoming the presumption in favor of equitable tolling, courts should create categorical exceptions for "big" programs, where the rule potentially would have large impacts, makes little legal sense and did not prevent this Court from applying equitable tolling in a case involving Social Security, a program larger Medicare. *Bowen v. City of New York*, 476 U.S. 467 (1986).

More specifically, the Secretary's ultimate contention is that the sheer size of the Medicare program, and the potential financial consequences of allowing equitable tolling to redress the loss of rights as a result of government misconduct, should warrant a categorical exclusion of the Medicare program from equitable tolling principles. However, the Secretary's own regulations authorize reopening "at any time" of Medicare payment determinations that were "procured by fraud or similar fault," which the Secretary has defined to include "deliberate concealment of information" -- the very government misconduct that the Hospitals allege occurred here.

Moreover, while the Secretary raises the spectre of large numbers of baseless claims being asserted by hospitals that have slept on their rights, the record here is entirely undeveloped, and the precise nature of the potentially-burdensome equitable tolling claims unexplored in the record. Further, as shown below, the spectre of masses of meritless claims being asserted on the basis of the decision below is a chimera. The Secretary fails to acknowledge that equitable tolling is a narrow doctrine, properly invoked (as this Court has said) "only sparingly," in response to government misconduct, and only by a claimant that has itself

exercised due diligence. *Irwin*, 498 U.S. at 96. And, even though the Secretary identifies no court that has ever barred the application of equitable tolling to Medicare cases, the doctrine is rarely invoked. Thus, the primary answer to the Secretary's suggestion that the doctrine will be too generously applied, and too frequently invoked, lies in the well-established, historic limitations on the doctrine's reach. Those limitations are left unaddressed on this record and in the petition.

The truth is that the general availability of the doctrine creates no administrative burden because the circumstances under which the doctrine may be invoked under a program like Medicare – where there is a clear duty of diligence on hospitals to pursue factual issues within their ken or control – have been rare, despite the fact that at least one district court explicitly applied it in an unappealed decision more than a decade ago. The doctrine is limited to the improper withholding of information within the control of the Government. Moreover, while the Secretary complains that the doctrine, if left unconstrained, may subject her to large numbers of meritless, but burdensome, reimbursement petitioners, the Secretary fails even to consider her ability to implement regulations that might limit or channel the inquiry whether equitable tolling is proper in particular cases. Of course, the Secretary can avoid the doctrine entirely by operating the Medicare program with transparency, as required by long-standing Executive Orders.[1]

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[1] For example, Exec. Order No. 12,866, 3 C.F.R. 638 (1994), *reprinted as amended in* 5 U.S.C. § 601 requires that (continued...)

Indeed, the Secretary's own argument about the burden of allowing equitable tolling to be invoked in the context of Medicare reimbursement decisions is internally inconsistent. On the one hand, the Secretary argues in favor of interlocutory consideration of the ruling below by invoking the administrative burdens of some wave of requests for hearings that might follow if the D.C. Circuit precedent is allowed to stand. Pet. 27-30. But at the same time, the Secretary notes that if indeed some large number of hospitals are affected by the Secretary's improper withholding of information that has prevented the hospitals from knowing that they were being shortchanged -- the allegation here -- they typically join together in group appeals to present their common claims and, as here, hold later-filed cases in abeyance while a lead case pursues the issue. Pet. 28. The routine use of a lead case, and group joinder of claims, to allow common issues to be conclusively resolved together, undermines the alleged administrative burden of addressing some large number of claims affected by government misconduct. Ultimately, however, the mere burden on the Government of complying with the law does not render a case certworthy when it is otherwise undeserving of this Court's attention.

(continued)
once a rule is published, the Office of Information and Regulatory Affairs ("OIRA"), within the Office of Management and Budget, must make available to the public "all documents exchanged between OIRA and the agency during the review by OIRA." Exec. Order No. 12,866, at § 6(b)(4)(D). This should put hospitals on notice of issues that need to be appealed, thereby limiting the availability of an equitable tolling claim.

The issue is, therefore, not ultimately one of administrative burden, but rather that if there is an adverse decision on equitable tolling -- that the Government's misconduct induced hospitals to fail to timely assert claims for reimbursement that they were entitled to receive by statute -- the financial consequences to the Government can be large. But if that were to be the result, this Court would have the opportunity to consider all of the issues related to the ruling, including the specific lower court ruling presented here, on a full record, in a developed factual context. The solution is not to address the issue now, in the absence of a factual record, in order to exclude any and all Medicare reimbursement decisions from the reach of the equitable tolling doctrine in the absence of any identifiable reason why the doctrine does not apply. Moreover, even if the Government were at risk for substantial liability as a result of this decision, as the court of appeals noted in another case: "Having to pay a sum one owes can hardly amount to an equitable reason for not requiring payment." *In re Medicare Reimbursement Litig., Baystate Health System v. Leavitt*, 414 F.3d 7, 13 (D.C. Cir. 2005), *cert. denied*, 547 U.S. 1054 (2006).

The petition does not even argue that the decision below conflicts with any precedent of this Court and identifies no decision in conflict with the decision in this case. At most, the petition argues that the D.C. Circuit misapplied this Court's precedent. Moreover, the Secretary does not say, nor could she, that the D.C. Circuit applied any standard that is inconsistent with this Court's decisions. Again, at most, the petition argues that the D.C. Circuit misapplied the standards adopted by this Court. But, this Court does not sit to correct errors

in the application of established precedents and this alleged error is not worthy of review. And there is no conflict here. The D.C. Circuit's decision upholding equitable tolling under Title XVIII of the Social Security Act -- the Medicare Act -- is not in conflict with any other decision of any federal appellate court, and it is fully consistent with this Court's holding in *Bowen v. City of New York, supra*, applying tolling to another analogous provision in Title II of the Social Security Act, which Congress incorporated into the Medicare review scheme at issue here. Finally, the stale conflict argued in the petition is not actually a conflict involving the decision in this case.

In sum, for the reasons summarized here, and elaborated below, the petition should be denied.

COUNTER-STATEMENT

The petition sets forth the statutory and regulatory framework, as well as the history of the case. Therefore, the Hospitals here emphasize only a few salient points that bear directly on the question whether the petition should be granted.

A. The Statutory and Regulatory Framework Is Incompatible with the Secretary's Position

As explained in the petition, the Medicare program establishes a system of payments for services provided to Medicare beneficiaries by, *inter alia*, hospitals. The total payment due to a hospital for a fiscal year for services rendered to Medicare beneficiaries is initially determined by a fiscal intermediary -- a Health and Human Services ("HHS") contractor -- which issues a notice of program reimbursement setting forth the total

Medicare payment amount the intermediary proposes that the hospital be paid for the services provided during the fiscal year. 42 C.F.R. § 405.1803 (2011). The hospital can, of course, contest the determination by making a claim for additional compensation.

By statute, a hospital seeking to contest the notice is granted 180 days to request a hearing before the Provider Reimbursement Review Board ("PRRB" or "Board"). 42 U.S.C. § 1395oo(a)(3). To all appearances, this time limitation on the ability to press a claim for additional Medicare payment looks like an ordinary limitations period. The statute provides that the appeal may be pursued:

> If – . . . (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph 1(A)(i), or with respect to appeals under paragraph 1(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. § 1395oo(a)(3). Thus, the time limitation is structured to afford the hospital, the provider of Medicare services, a means of recourse if it feels the Secretary, or the intermediary acting on the Secretary's behalf, has not authorized the proper total Medicare payment to which it is entitled. The statute confirms that the same 180-day time limitation applies where (a) the intermediary timely issues a reimbursement notice, (b) the Secretary has herself made a payment determination (typically in

a regulation), or (c) the intermediary has failed to timely issue a reimbursement notice.

Significantly, the Secretary has never suggested, does not suggest, and could not suggest, that this statutory time limit is, or was intended *by Congress* to be, absolute and not subject to equitable considerations in its administration. The Secretary does not and cannot contend that considering claims beyond the 180-day limitations period prescribed by statute would contravene either the text of the statute or the intent of Congress in enacting it. To the contrary, the Secretary, by regulation, has herself *broadly* allowed relief from the 180-day limitation for good cause shown, for up to three years after the determination. 42 C.F.R. § 405.1841(b) (2007).[2] The Secretary must acknowledge that allowing such relief is, at a minimum, consistent with both the text of the statute and Congressional intent. Thus, the Secretary's assertion of her own broad authority to provide relief from the 180-day limitation for a wide range of equitable reasons is fundamentally inconsistent with the notion that allowing relief from the limitations period for the single most time-honored, and well-justified of equitable reasons -- encapsulated in the equitable tolling doctrine as a remedy for a defendant's misleading behavior -- is somehow inconsistent with the statute or Congress's will.

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[2] The Hospitals cite to the 2007 version of 42 C.F.R. § 405.1801 *et seq.* because the 2008 amendments to those regulations apply only to Medicare payment administrative appeals pending as of August 21, 2008. 73 Fed. Reg. 30,190 (May 23, 2008). The Hospitals, however, exhausted the administrative process for their appeals before that date.

The Secretary does *not* suggest that her own regulation allowing relief from the 180-day period was itself an effort to structure or channel traditional equitable tolling claims or addresses the unique considerations associated with a traditional equitable tolling, including the very basic principle that tolling is appropriate only where the Government is uniquely possessed of information *not* available to the hospital and has wrongfully concealed that information, thus preventing the hospital from knowing that there is something wrong, giving rise to a potential challenge. Neither does the Secretary suggest that any of her regulations could in any way preempt or circumscribe equitable tolling principles already implicit in the statute. To the contrary, it appears to be the Secretary's position that while she possesses broad authority to announce exceptions to the 180-day period, which will *not* undermine the administrative scheme, the narrow, traditional rule of equitable tolling associated with most limitations periods, to guard against abuse, is somehow out-of-bounds.[3]

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[3] The Secretary argues that the decision of the court below, if allowed to stand, "would impose a considerable administrative burden on HHS and would expose the Medicare Trust Fund to substantial and unpredictable liabilities for past cost years that have long since been closed." Pet. 10-11 (underlining added). Of course, the fact that the Secretary already allows claims to be reopened for three years diminishes any additional burden from allowing equitable tolling in the narrow circumstances where it is appropriate. Moreover, the Secretary long ago adopted a regulation making all past cost years subject to correction *at any time* where the determination was the result of "fraud or similar fault" (42 C.F.R. §

(continued...)

B. The Decision Below Rejected the Secretary's Claim to a Categorical Exemption from Equitable Tolling Principles

The Hospitals sought to challenge a series of determinations by their respective intermediaries for the years 1987-1994. The PRRB rejected their claims as untimely and held that it lacked any general authority to recognize equitable exceptions to the limitations period not expressly authorized by HHS regulations. App. 55a-56a.

The Hospitals ultimately appealed to the United States District Court for the District of Columbia. There the Secretary persuaded the district court judge that the PRRB's determination that these claims were untimely was somehow *not* a final decision subject to judicial review and, even if it was, the 180-day limitation period could not be equitably tolled. App. 29a and 35a. Although the Secretary had contended that the facts would *not* justify equitable tolling under that doctrine as properly (and narrowly) construed, it did not press that contention in its motion. It posited instead the categorical rule that equitable tolling would not be available to a hospital in any circumstances involving the Medicare payments at issue.

The Court of Appeals panel, Circuit Judges Henderson and Griffith, and Senior Circuit Judge

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(continued)
405.1885(b)(3) (2011); 42 C.F.R. § 405.1885(d) (2007)), which the Secretary has defined as, *inter alia*, "deliberate concealment of information." Medicare Claims Processing Manual, Chapter 29, § 90.9 (as cited below).

Williams, rejected both of the district court's principal rulings.

The Court of Appeals first held that the federal courts did indeed have jurisdiction to consider the Hospitals' appeal. App. 5a. The Government apparently *no longer* suggests otherwise.[4]

The Court of Appeals likewise rejected the contention that the 180-day period is not, in a proper instance, subject to equitable tolling. App. 10a. The Court of Appeals began by noting three uncontroversial principles, reflected in this Court's cases that ultimately controlled the disposition of this case: (1) that it is hornbook law that limitations periods are customarily subject to equitable tolling, unless equitable tolling would be inconsistent with the text of the relevant statute; (2) that "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States" (quoting *Irwin*, 498 U.S. at 95-96); and (3) that the presumption in favor of recognizing equitable tolling is not disturbed by the fact that the issue arises in the context of a government benefits program like Medicare (citing, as an example, *Scarborough v. Principi*, 541 U.S. 401, 422 (2004)). App. 5a-7a.

The Court of Appeals found nothing in the statutory text to suggest that Congress wished to bar the application of the doctrine to the 180-day period. To the contrary, the statute describes the 180-day limitation period in conventional and "fairly simple"

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[4] Whether the Government would expect this Court to address and resolve the jurisdictional issue if certiorari were granted is left unclear in the petition.

terms, similar to other statutes in which the applicability of equitable tolling has been recognized. App. 9a. The Court of Appeals also recognized that the basic nature of the claim, a fee paid for a service rendered, left it roughly analogous to a contract claim for work performed. App. 6a n.1.

In particular, the Court of Appeals rejected the Secretary's effort to analogize the case to the limitations period for tax refund claims at issue in *United States v. Brockamp*, 519 U.S. 347 (1997). App. 7a-10a. In *Brockamp*, Congress, by statute, had enacted a set of comprehensive exceptions and limitations in a highly detailed and technical manner, with a range of interdependent provisions. Thus, it was reasonable to conclude that *Congress* had fully and comprehensively addressed the circumstances where relief from the time limits in the statute itself, leaving no room for other, even conventionally implied, exceptions. There were no comparable provisions here. To be sure, the "good cause" exception of 42 C.F.R. § 405.1841(b) (2007) might be relevant. But that exception is in the regulations, not the statute, "... and does not bear on whether Congress rebutted the presumption of equitable tolling by enacting a complex set of exceptions to the statute of limitations." App. at 9a.

On that basis, the Court of Appeals reversed and remanded for a determination whether the doctrine had any proper application here.[5] App. 10a.

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[5] The Secretary notes that the Court of Appeals remanded this case to the district court and "assume[s]" that the Court of Appeals "intended the district court to first remand to the [Provider Reimbursement Review] Board for (continued...)

The government filed a petition for rehearing, which failed to garner even a request for a vote. App. 64a. Judge Griffith, joined by Senior Judge Williams filed an opinion concurring in the denial of rehearing *en banc*. App. 65a-66a. In that separate opinion, they emphasized that there was absolutely no textual basis upon which to conclude that Congress intended to preclude equitable tolling, again contrasting the statutory text with the emphatic, detailed, and repeated limitations provisions statutorily stated in *Brockamp*. App. 66a.

REASONS FOR DENYING THE WRIT

The Secretary presents no reasonable or responsible argument that the decision below does anything more than follow this Court's established precedents on the availability of equitable tolling in the context of a claim against the Government. There is simply no textual indication that Congress intended for the 180-day period governing claims against the Government for reimbursement under the Medicare program to be any more absolute than most limitations periods, *i.e.* subject to limited equitable exceptions necessary to prevent gross injustice at the hands of the Government.

(continued)
'any further factual development.'" Pet. 8 n.5. However, the PRRB's 2008 regulations limit discovery that is available against the Secretary and the Centers for Medicare & Medicaid Services ("CMS") (42 C.F.R. § 405.1853(e)) and prohibits the PRRB from issuing a subpoena to the Secretary and CMS (42 C.F.R. § 405.1857(a)). Thus, the Hospitals expect the process for further factual development to be considered by the district court in accordance with the remand order of the Court of Appeals.

Notwithstanding the Secretary's arguments that allowing equitable tolling will give rise to onerous administrative burdens, the narrowness of the equitable tolling doctrine, and the Secretary's own historic willingness to allow the time for claims to be appealed to be extended for up to three years for good cause, and to allow corrective reopening *indefinitely* where information relevant to a payment was deliberately concealed, thoroughly undermine that argument. And the Secretary's effort to manufacture a conflict of some sort among the Circuits by reviving stale Circuit Court rulings on some arguably related point that have, in fact, been long since superseded by this Court's own decisions, rings entirely hollow.

In truth, the petition rests on the notion that if equitable tolling is allowed generally, and is proven applicable in this case, the fiscal burden of requiring the Government to pay precisely what it owed the Hospitals, under statute, for the services they provided could be large. But even if that could be a proper ground for certiorari (which it is not), it certainly does not justify consideration of the issue in its current interlocutory posture, for there would be time enough to address the issue presented here, along with any other issue concerning the right to tolling in light of the government's conduct, if and when the issues have been addressed by the agency and/or the lower courts.

I. The Court of Appeals Correctly Applied This Court's Precedents And The Application Of Those Precedents Does Not Call For This Court's Review

In *Irwin*, 498 U.S. at 95-96, this Court held that "the same rebuttable presumption of equitable

tolling applicable to suits against private defendants should also apply to suits against the United States. Congress, of course, may provide otherwise if it wishes to do so." And this rule is a corollary of the more general understanding that "limitations principles should apply generally to the Government in the same way that they apply to private parties." *See Franconia Associates v. United States*, 536 U.S. 129, 145 (2002). The rationale for that presumption in favor of equitable tolling is, of course, two-fold. The exception to the strict application of limitations periods under the doctrine of equitable tolling has long been understood as part of limitations law and there is ordinarily no reason to believe that Congress would wish to disavow it. Moreover, the application of the equitable tolling doctrine, at least in the narrow form applied in the federal courts, is simply designed to prevent fundamental injustices, such as allowing the defendant to profit from misleading the complainant and inducing the complainant to allow a deadline to pass. Thus, the presumption that Congress expected equitable tolling of limitations periods for claims against the Government, just as in connection with private suits, reflects "a realistic assessment of legislative intent as well as a practically useful principle of interpretation." *Irwin*, 498 U.S. at 95.

That basic principle of statutory interpretation of federal limitations provisions has not proven overly difficult to understand – though it appears fair to say that the Government has frequently resisted its application. Congress itself has been alerted to the presumptive rule for interpreting its enactments, and thus that it has the power to change it if it leads to undesired results, either generally, or in particular contexts (which it has not

done for the statute at issue, despite revisiting it six times since *Irwin* was decided (Pet. 13 n.6), five of which provided cross-references to where judicial review is *not* available (as explained below)). And this Court too has repeatedly and recently reaffirmed *Irwin's* breadth, noting that it extends beyond causes of action with ready common law analogues (like this case), and also in connection with statutes that create special rights against the Government. "*Irwin*'s reasoning would be diminished were it instructive only in situations with a readily identifiable private litigation equivalent." *Scarborough*, 541 U.S. at 422.

The Secretary here primarily relies on *United States v. Brockamp*, *supra*. In *Brockamp*, this Court rejected the application of equitable tolling in the context of the complex, comprehensive, and emphatic time limits on tax refund claims. The special governmental nature of the taxing power is, of course, readily distinguishable from the types of claims at issue here.[6]

The claims at issue here are for proper reimbursement for services rendered to Medicare beneficiaries, which the Secretary allegedly

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[6] Moreover, and more importantly, the circumstances under which the claims arose were also quite different. In *Brockamp*, in "each case a taxpayer initially paid the Internal Revenue Service (IRS) several thousand dollars that he did not owe. In each case the taxpayer (or his representative) filed an administrative claim for refund several years after the relevant statutory time period for doing so had ended." *Brockamp*, 519 U.S. at 348. Thus, claimants in *Brockamp* negligently made erroneous payments, which they untimely sought to recover. There was no allegation that the IRS acted improperly with regard to the erroneous payments.

underpaid and which the Hospitals did not timely appeal because of the Secretary's deliberate concealment of information about the cause of the underpaid claims. Though the Medicare program is complex (as are many private contracts), the basic claim at issue here is fundamentally analogous to a contract (or, reaching back further, an action in *assumpsit*), *i.e.* an entitlement to payment on stated terms for services rendered (as opposed to an effort to recover an improper payment, negligently made and untimely claimed, against a defendant who did not act improperly). Unlike *Brockamp*, this is a context in which entitlement to payment, and the inequity of denying payment for those services where the claimant has been misled and induced by the payer into allowing an applicable time limit to pass, is easily seen. In any event, this Court has made clear that in judging whether equitable tolling is available, it is helpful that the claim at issue resemble a common law claim, but no "readily identifiable private litigation equivalent" (*Scarborough*, 541 U.S. at 422) is required.[7]

Of course, as special as the tax code may be, this Court did not rest its decision in *Brockamp* on judge-conceived postulates and intuitions about whether equitable tolling would be appropriate in connection

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[7] There is, in fact, an exact "private litigation equivalent" for the claims at issue. Private risk-bearing health plans, known as Medicare Advantage plans, acting pursuant to contracts with HHS, are now responsible for almost 20% of all Medicare payments. If a hospital is dissatisfied with the payment it receives from a Medicare Advantage plan for providing care to Medicare beneficiaries, including the Part A payments at issue in this case, the hospitals bring private litigation against the plans.

with particular government programs. Rather, the Court properly looked to the statutory text itself and found that the comprehensive, repeated, and emphatic references to the limitations period in the statute left little room for the implication of an equitable tolling exception, and thus *textually* rebutted the presumption that tolling applies. As the D.C. Circuit panel repeatedly noted, there is no textual basis to suggest that principles of equitable tolling were not intended to apply here (it is also not clear that the equities favored the taxpayer in *Brockamp* in that, unlike as alleged here, the IRS did not conceal any information, deliberately or otherwise).

The Secretary strains to suggest textual complexity, and the kind of comprehensive treatment of limitations, found in *Brockamp*. In support of that theory, she asserts that the "time deadline is just one of three mandatory preconditions to invoking administrative review," and neither of the other two "mandatory preconditions" is amenable to tolling. Pet. 19. Of course, it is odd indeed to see the provider's "dissatisfaction" with the ruling characterized as a "mandatory precondition" to the provider's right to seek review -- but it does illustrate the weakness in the Secretary's theory. And the amount in controversy requirement, as a precondition to invoking the right of review (42 U.S.C. § 1395oo(a)(2)), is a perfectly conventional limitation on bringing a claim. That an amount in controversy requirement may not be subject to equitable considerations (though it is unclear what they might even be), says nothing at all about whether limitations periods, which are historically and

conventionally subject to equitable tolling, is or is not subject to equitable tolling under this statute.

The petition, at 9-10 and 20, takes the Court of Appeals to task because it allegedly "failed to appreciate the significance of the fact that Section 1395oo(a)(3) prescribes a deadline for filing an administrative appeal with the PRRB, not a statute of limitations for filing suit in federal court." The categorical distinction that the Secretary proposes between administrative claims and court claims for purposes of the application of equitable tolling simply does not wash. In *Brockamp*, this Court considered an internal administrative appeal. If that was enough to rule out the application of equitable tolling, the opinion would have begun and ended at that. But this Court did not deem that to be a viable distinction. To the contrary, it engaged in the textual analysis and evaluation that plainly distinguishes this case from that one. *See Brockamp*, 519 U.S. at 350-352. This distinction was also rejected in *Bowen v. City of New York*, 476 U.S. at 482, where this Court stated:

> At the outset, we note that by the time this lawsuit was filed, it was too late for a large number of class members to exhaust their claims, since expiration of the 60-day time limits for administrative appeals barred further access to the administrative appeals process. (citations omitted). For these claimants, we conclude that exhaustion is excused for the same reasons requiring tolling of the statute of limitations.

Thus, the Secretary errs by suggesting that *City of New York* only involved "the 60-day limitations period for seeking *judicial* review . . . ." Pet. 18 n.9 (emphasis in original).

Absent some meaningful textual rationale for rejecting equitable tolling, the Secretary's assertion that tolling should be categorically rejected because it is somehow incompatible with Medicare would necessarily rest on judicial imaginings of a proper *ipse dixit* rule. At a minimum, it would leave the instruction of *Irwin* -- recognizing that Congress itself ordinarily intends its limitations periods to be subject to equitable tolling, presumably unless it says otherwise -- without any force at all.

Moreover, the Secretary cannot make the one argument that she would perhaps most like to make in arguing against allowing relief from the 180-day requirement for equitable tolling: that the limitations period was intended by Congress to be rigorously applied and, in effect, jurisdictional (as, she suggests, is the amount in controversy requirement), and cannot tolerate exceptions. That argument is not made because the Secretary has long had in place regulations that effectively allow relief from these limitations for, among other things, good cause (42 C.F.R. § 405.1841(b) (2007); 42 C.F.R. § 405.1836 (2011)), and a regulation that protects the Medicare program indefinitely from payments based on a provider's deliberate concealment of relevant information (42 C.F.R. § 405.1885(d) (2007); 42 C.F.R. § 405.1885(b)(3) (2011)).

The notion that the 180-day period was intended by Congress to be so rigid that it displaces a time-honored, equitable exception, which was designed to prevent injustice at the hands of the

defendant, and which is recognized as implicit in virtually all limitations periods, but somehow not so rigid as to allow the Secretary to create equitable exceptions of her choosing, is hard to sustain -- and certainly finds no support in any statutory text or decisions of this Court.

Significantly, the Secretary does not suggest that her own regulatory exceptions to the 180-day period could somehow preempt or supersede the doctrine of equitable tolling implicit in the statute. And while the Secretary complains that allowing equitable tolling will subject her to untold numbers of meritless claims in the future, she does not consider whether, for example, consistent with the D.C. Circuit's decision, she can mitigate the claimed burden of equitable tolling by using her rulemaking authority. The Secretary does not consider how she may, through regulation, require greater diligence on the part of hospitals, or set forth more clearly the information that will be made available to hospitals or which they may request, thereby limiting the availability of equitable tolling in a manner consistent with the statute and the doctrine itself. All these potential mitigating measures are left unexplored in the petition, while the Secretary cites administrative burdens as justifying the categorical exclusion of her Medicare program from principles of equitable tolling.

II. The Secretary's Claims Of Administrative Burden Ring Hollow

This Court has not suggested that a court's intuitions and gleanings about the possible administrative burden of allowing equitable tolling in a particular setting could, in the absence of some meaningful textual indication that equitable tolling

is not to be allowed, suffice to allow the courts to imply a bar on equitable tolling with respect to some specific limitations period.[8] Nonetheless, the Secretary repeatedly posits a parade of horribles that would follow from allowing equitable tolling in the context of Medicare reimbursement, all flowing from some flood of entirely meritless claims that she sees as authorized by the D.C. Circuit's opinion.

At the outset -- as pointed out above -- claims of administrative burden are significantly weakened by the fact that the Secretary has long allowed relief from the 180-day period simply upon a showing of good cause (albeit, allowing such relief for only three years after the decision). Having allowed that broad relief, albeit limited as to time, the Secretary could only complain of the *incremental* burden of allowing a narrow exception to the time limit for equitable tolling to apply for a somewhat longer period of time.

Nonetheless, the Secretary repeatedly raises the spectre of administrative burden flowing from an avalanche of meritless claims as reason for categorically rejecting the applicability of equitable tolling. Indeed, this purported avalanche of meritless claims that will supposedly flow from allowing the D.C. Circuit's opinion to stand, for even a short time, provides the sole rationale offered by the Secretary why this Court should grant the petition in the case's interlocutory posture, rather

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[8] Even the district court, accepting the Secretary's argument, acknowledged that the statute at issue here lacks the decisive complexity associated with the tax refund limitations period at issue in *Brockamp*. App. 35a.

than wait for a final decision, and address the issues on a complete and proper record. Pet. 28 n.15.

The Secretary's argument is fundamentally misguided and the claimed burdens ephemeral and wholly lacking in support in the record of this case. The federal doctrine of equitable tolling redresses only gross injustices. As this Court has made clear, the doctrine is applied "only sparingly," in narrow circumstances. *Irwin*, 498 U.S. at 96 (summarily rejecting the application of the doctrine on the claim presented). To the extent relevant here, it is, as this Court explained, available "where the complainant has been induced or tricked by his adversary's misconduct in allowing the filing deadline to pass." *Id.* The doctrine typically does *not* excuse a failure of the complainant to exercise due diligence and timely pursue all legal and factual issues available. The reason it is plausibly available in this case, as alleged, is that the information deceptively concealed from the Hospitals, was *not* something that the Hospitals could have known and the Hospitals were misled by the Secretary with regard to a payment determination that is made entirely by the Secretary without any input from any provider. A payment determination made entirely by the Secretary without provider input is actually quite rare in Medicare.

Thus, the Secretary's effort to invoke "each of the tens of thousands of sophisticated Medicare-provider recipients" who are "generally capable of identifying an underpayment in its own [Medicare notice of program reimbursement] within the 180-day time period," but instead choosing to hold back and "evade" the 180-day time limitation (and three-year "good cause" time extension provision), is

unconvincing. Pet. 26. Such claims could not plausibly be brought. Underpayments that can be readily identified by the provider are simply not within the scope of the doctrine. Neither could "health care consulting" firms "scour old cost reports looking for" errors -- because if the errors are there to be seen, they must be timely asserted. The circumstances giving rise to plausible claims for equitable tolling simply do not arise very often -- and if they do, are almost invariably the product of the kind of misconduct and injustice that commands that relief be granted. Equitable tolling is a remedy for injustice, not its cause.

Finally, in the very rare circumstances where, in the context of Medicare reimbursement, plausible claims for equitable tolling might be presented, the "statute and regulations permit health care consulting firms to bring group appeals on behalf of large numbers of providers." Pet. 28. When multiple group appeals are filed, one is typically designated as the lead case for purposes of judicial review. This is precisely what happened here and in *In re Medicare Reimbursement Litig., supra,* where later-filed cases were held in abeyance pending the outcome of the lead case.

Significantly, equitable tolling does not eliminate the limitations period, but merely tolls its application for a period of time. Claimants are required to proceed diligently after the facts that had been concealed have become known. Thus, there is no reason to expect large numbers of duplicative proceedings arising out of some common error: if a case for tolling did arise, it could be addressed and resolved with relative efficiency. While it cannot be said that acknowledging the availability of equitable

tolling will impose *no* burdens on the agency -- nor should it because it is, after all, largely a means of correcting for misconduct that causes a provider to lose its rightful payment for services rendered -- the parade of horribles suggested by the Secretary is well wide of the mark. Indeed, as Judge Griffith noted in the statement accompanying the order denying the Secretary's petition for rehearing *en banc*: "Although it is no doubt true that the complex Medicare reimbursement scheme will be more difficult to administer with equitable tolling available to claimants, that factor alone is not enough to persuade us that Congress rejected the presumption of equitable tolling with the type of clarity the precedents require." App. 66a.

The real "burden" here is not administrative, but potentially financial if the government misconduct at issue, properly pleaded and proved, results in some large number of providers being improperly deprived of the payments that they were entitled to receive for the services they provided to Medicare beneficiaries. It is, however, hard to see how the Secretary is burdened by paying the amounts required to have been paid by statute many years after the payments should have been made. But even assuming that could be the basis for a certiorari petition (which it cannot), the proper time to consider such a factor would be on final judgment, when the facts could be assessed and the circumstances considered. It is surely not appropriate to speculate about such possibilities on this interlocutory record.

III. The Secretary's Effort to Manufacture a Circuit Conflict Is Strained and Unconvincing

Straining to manufacture a circuit-split on account of the D.C. Circuit's decision in this case, the Secretary asserts that "the court of appeals' decision cannot be reconciled with" rulings of the Eighth and Eleventh Circuits. Pet. 23.

Even the Secretary recognizes, however, that there is no actual circuit-split on the question at issue in this case, *i.e.*, whether equitable tolling applies to the 180-day time limitation for seeking PRRB hearings pursuant to 42 U.S.C. § 1395oo(a)(3). As she ultimately acknowledges, "neither [the Eighth nor the Eleventh Circuit] court[s] specifically considered the question of equitable tolling." Pet. 24. Thus, by the Secretary's own admission, the specific issue presented by this appeal is not subject to a circuit-split and the petition, thus, should be denied.

In reality, what the Secretary references is a very old and stale, but certainly very different, circuit-split concerning her authority to enact the "good-cause" regulation contained in 42 C.F.R. § 405.1841(b) (2007). *See Lenox Hill Hospital v. Shalala*, 131 F. Supp. 2d 136, 142 n.6 (D.D.C. 2000) ("There is a circuit split on the lawfulness of the Secretary's good-cause regulation."). The Ninth Circuit Court of Appeals ruled in 1986 that the Secretary did not exceed statutory authority by promulgating the "good-cause" exception. *Western Medical Enterprises, Inc. v. Heckler*, 783 F.2d 1376, 1379 (9th Cir. 1986). A few months later, the Eighth Circuit reached an opposite result, "conclud[ing] that the Secretary had no authority to promulgate a regulation that effectively expanded the jurisdiction

of the PRRB to entertain untimely appeals." *St. Joseph's Hospital v. Heckler*, 786 F.2d 848, 852 (8th Cir. 1986). As the Secretary notes, the Eleventh Circuit concurred with the Eight Circuit's approach. *Alacare Home Health Servs., Inc. v. Sullivan*, 891 F.2d 850 (1990).[9] The question in those cases concerned the Secretary's "power to promulgate the regulation" that she had adopted. *Western Medical*, 783 F.2d at 1379. In short, the circuit-split concerns the question of whether or not the Secretary has the authority to create *ad hoc* exceptions of her own making in implementing the 180-day limitations period. It has nothing to do with whether or not the Medicare Act generally, or the 180-day limitations period specifically, are subject to the historic principle of equitable tolling. [10]

Nonetheless, the Secretary tries to create the misimpression that the circuit-split she references is new and results directly from the D.C. Circuit's decision in this case. Pet. 24. However, the only

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[9] The D.C. District Court sided with the Ninth Circuit on this issue. *Ozark Mountain Reg. Rehab Center v. DHHS*, 798 F. Supp. 16, 20 (D.D.C. 1992) ("the Court determines that § 405.1841(b) is valid.").

[10] In *Anaheim Mem'l Hosp. v. Shalala*, 130 F.3d 845, 853 (9th Cir. 1997), the Ninth Circuit reserved on the issue of equitable tolling ("Since the Board never resolved the equitable tolling issue, we remand to the Secretary for a final decision on the merits of Anaheim's equitable tolling claim."). The court in *Bradford Hospital v. Shalala*, 108 F. Supp. 2d 473, 484 (W.D. Pa. 2000), recognized that "numerous courts have applied equitable tolling to regulatory filing deadlines" and held that "equitable tolling is generally applicable to Medicare regulatory filings." The petition does not identify a case where a court has held that equitable tolling is not available to Medicare appeals.

actual conflict that the Secretary identifies concerns the Secretary's "good cause" regulation, not equitable tolling (". . . neither court specifically considered the question of equitable tolling."). *Id.* And the ostensible split over the good cause regulation would not be addressed or resolved in this case.

Moreover, the circuit-split concerning whether the "good cause" regulation is *ultra vires* is not new; it has existed for over a quarter of a century, stemming from the differing conclusions of the Ninth and Eighth Circuits in 1986. Thus, the conflict involving the validity of the "good cause" regulation, if it needs to be addressed at all in light of the change to that regulation discussed below, is best left to be addressed in a case where the validity of that regulation is actually at issue.

Further, even on an abstract or purely conceptual level, there is no "conflict" at all with any of the cases cited by the Secretary. There is nothing inconsistent between the view, on the one hand, that (a) the 180-day period of the statute incorporates, as a matter of presumptive Congressional intent, the doctrine of equitable tolling where that narrow doctrine is applicable and, on the other, (b) that the Secretary has no authority to create *ad hoc* exceptions of her own to the 180-day limit. Moreover, addressing the issue that arguably *is* presented by this petition -- whether equitable tolling is available under this statute -- will do nothing at all to resolve the conflict that the Secretary cites, *i.e.*, whether she has the power to create exceptions of her own to the 180-day period.

Nonetheless, the Secretary tries to generate a conceptual conflict by characterizing the prior cases as resting on the "jurisdictional" nature of 180-day

period. Pet. 24. But the injection of that terminology will not create a conflict where none exists. The cases cited by the Secretary hold that the Secretary had no power to enact the rule. Any effort to characterize this as a holding that the rule has "jurisdictional" significance -- and thus is not subject to exceptions for any reason -- simply will not wash under this Court's more recent cases. Indeed, as the district court explained, this Court has repeatedly "'[r]ecogniz[ed] that the word "jurisdiction" has been used by courts, including this Court, to convey "many, too many, meanings," [and] we have cautioned, in recent decisions, against profligate use of the term.'" App. 24a-25a (quoting *Union Pacific R. Co. v. Bhd. of Locomotive Eng'rs and Trainmen Gen. Comm. of Adjustment*, 130 S. Ct. 584, 596 (2009), quoting *Arbaugh v. Y&H Corp.*, 546 U.S. 500, 510 (2006)).[11]

Even if the claimed split over the good cause regulation could be resolved in this case, it is doubtful that the more than 25-year old split that the Secretary does identify remains real. As pointed out in the petition, the "good cause" regulation rejected by the Eighth and Eleventh Circuits is no longer on the books. Pet. 4 n.3 and 25 n.13. The Secretary has recently promulgated a new "good

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[11] The district court in this case observed that "it is important to note that the 180-day limitations period cannot plausibly be characterized as jurisdictional. . . . [T]here is no language in § 1395oo(a) or (f) indicating that the limitations period is jurisdictional. The Supreme Court has cautioned that, 'when Congress does not rank a statutory limitation . . . as jurisdictional, courts should treat the restriction as nonjurisdictional in character.' *Arbaugh v. Y&H Corp.*, 546 U.S. 500, 515-16 (2006)." Pet. 24a.

cause" regulation, which has apparently not been rejected by any court. *Id.* And it very likely would not be. As noted above, this Court's more recent cases -- in the more than 25 years since the Eighth and Eleventh Circuit rulings cited by the Secretary - have decisively rejected the tendency to characterize time limits as "jurisdictional" and thus unwaivable in any circumstances. Moreover, in *Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449 (1999), this Court had before it much of the Secretary's regulatory structure concerning the flexibility of the 180-day period, providing some limited further support for the Secretary's authority with respect to the 180-day limitations period. Significantly, the Secretary does not argue that anything in *Your Home* controls or determines the outcome here. In sum, if there will be (or even if it can be said that there remains) a circuit-split on the issue of the Secretary's exceptions to the 180-day rule, that split is not presented or addressed by the petition, and if it is important to the Secretary, can be addressed and resolved in a proper case.

CONCLUSION

The Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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May 2012

REPLY BRIEF

No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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In the Supreme Court of the United States

No. 11-1231

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONER

Since the creation of the Provider Reimbursement Review Board, the Secretary of Health and Human Services has prohibited the Board from extending the 180-day administrative appeal deadline in 42 U.S.C. 1395*oo*(a)(3), except as provided by regulation. For nearly 40 years, the applicable regulation has permitted an extension only for good cause shown and only if the request is filed within three years of the intermediary's Notice of Program Reimbursement (NPR). 42 C.F.R. 405.1841(b); 42 C.F.R. 405.1836 (2011).[1] And for the same 40 years, the Secretary has offered providers an opportunity to correct errors in the NPR of the sort respondents allege here (and recover underpayments) through a motion to reopen that likewise must be filed

[1] Unless otherwise indicated, all references to Title 42 of the C.F.R. are to the 2007 version.

within three years. 42 C.F.R. 405.1885(a); 42 C.F.R. 405.1885(b) (2011). Under well-settled principles of administrative law, the Court should sustain this established statutory and regulatory framework and reject respondents' proposed open-ended equitable tolling regime. Such a regime would undo the repose those time limits afford and fundamentally alter the administrative appeals process that has governed Medicare provider payments from the beginning and thereby maintained order and finality in an exceedingly complex regulatory scheme.

Respondents contend that the Medicare Act itself requires equitable tolling and, thus, adherence to the framework established by the Secretary is not warranted. But the statutory text does not even mention tolling; rather, respondents rely solely on a presumption in favor of equitable tolling that has no application here. Without that thumb on the scale, the Secretary's considered judgment and reasonable regulations are controlling. And even with a presumption, the Secretary's judgment and reasonable regulations remain sound: equitable tolling has no place in the complex and technical world of Medicare provider payments. In the end, respondents fail to establish that the Secretary's regulations are arbitrary, capricious, or contrary to Section 1395*oo*(a)(3) of the Medicare Act.

ARGUMENT

A. Respondents Mischaracterize The Facts Of This Case And The Secretary's Regulatory Regime

Respondents tell a story of agency "misfeasance" involving the "knowing concealment of known errors" that has deprived them of money "promised" by Congress. Br. 3, 18, 20, 31, 32, 33, 34, 55, 56, 58. In respondents' view, such agency "misconduct" is protected by a regu-

latory regime that they say operates as a "one-way tolling rule," allowing "perpetual reopening when a provider is at fault, but not when the Secretary is at fault." Br. 18, 19, 38, 39 n.13, 48, 50, 51, 55, 56, 58. Notwithstanding the number of times respondents retell that story, it is wrong.

1. Respondents' charges of "misfeasance" arise from administrative and judicial proceedings brought by Baystate Medical Center (Baystate). Baystate (unlike respondents here) timely appealed its disproportionate share hospital (DSH) adjustment determinations. The Board ultimately concluded that the information used by the Centers for Medicare & Medicaid Services (CMS) to calculate the SSI fraction was not "the best available data" and that there were flaws in the data-matching process. *Baystate Med. Ctr.*, PRRB Dec. No. 2006-D20, 2006 WL 752453, at *33-*34 (Mar. 17, 2006); see *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, 26-31, amended in part, 587 F. Supp. 2d 37 (D.D.C. 2008) (*Baystate*).[2] The Administrator reversed in relevant part, concluding that the Board was wrong to require CMS to achieve "an errorless match" in computing the SSI fraction and that, even using the provider's sample, only "approximately 1.59 percent of the individuals failed to match" and thus the provider failed to demonstrate that its reimbursement was adversely affected by

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[2] CMS calculates the SSI fraction because it "[r]ecogniz[ed] the difficulty hospitals would have identifying their Medicare patients who are also SSI recipients." 51 Fed. Reg. 31,459 (1986). To "remove[] this burden from hospitals," CMS decided to "undertake[] the task (and expense) of determining for each hospital the number of patient days of those dually entitled to Medicare Part A and SSI." *Ibid.*; cf. 60 Fed. Reg. 45,812 (1995) ("Because the SSI data used in the calculation are protected by the Privacy Act, we cannot provide an opportunity for hospitals to verify these data.").

the asserted errors. *Baystate*, 2006 WL 1684639, at *26, *35 (May 11, 2006). The district court in turn reversed in part, holding that CMS had not used "the best available data" to calculate the SSI fraction. *Baystate*, 545 F. Supp. 2d at 40-50. Specifically, the court concluded that CMS should have but did not use the most up-to-date SSA data in its possession, *id.* at 42-43, and that the data used omitted certain types of records that SSA could have included, *id.* at 44-46.

Contrary to respondents' allegations, no administrative or judicial tribunal has ever found that CMS "affirmative[ly] conceal[ed] known errors." Br. 19. Indeed, the district court and the Board both found precisely the opposite. The district judge in this case, who was also the district judge in *Baystate*, stated unequivocally that "nothing in either [the Board's or the district court's] *Baystate* decisions reflects a finding that CMS 'deliberately concealed' the data flaws at issue or otherwise engaged in fraud." Pet. App. 44a. The court explained that, in *Baystate*, the Board simply "rejected the contention that CMS had used the 'best available data,'" and the *Baystate* court reached the same conclusion. *Ibid.* The Board has similarly made clear that "[t]he decisions in *Baystate* did not result in a finding of fraud." *Medical Coll. of Ga. Hosp.*, PRRB Dec. No. 2010-D30, 2010 WL 4214223, at *4 (May 25, 2010), aff'd, 2010 WL 5570990 (CMS Adm'r July 13, 2010). The administrative and judicial findings that CMS failed to use the best available data to calculate the SSI fraction bear little resemblance to the "knowing[] and systematic[]" effort to underpay providers that respondents seek to portray. Br. 3.[3]

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[3] After the district court's decision in *Baystate*, the Secretary revised the matching process for all Medicare providers through notice-

Respondents' related suggestion that CMS is able to "conceal its errors until the clock runs out" (Br. 58) ignores a critical fact: respondents were in the same position as the hospital in *Baystate*. In 1999, Baystate timely challenged the intermediary's calculation of its DSH adjustments and "mounted diligent efforts" to obtain records from CMS and SSA. *Baystate*, 545 F. Supp. 2d at 51; A.R. at 8767-8768, *Baystate*, *supra* (No. 1:06-cv-1263) (11/19/99 Letter from Baystate to PRRB). The *Baystate* proceedings were paid for by a healthcare consulting firm that represents hundreds of other DSH hospitals and that negotiated a 35% contingency fee to prosecute *Baystate*. Southwest Consulting Assocs. Amicus Br. 1-3, 19 (Southwest Amicus Br.); *Baystate*, 545 F. Supp. 2d at 34 n.22. Beginning in 1993, the consulting firm began looking into what it believed were errors in CMS's calculation of the SSI fraction and ultimately "advise[d] Baystate to question the agency's SSI calculations." Southwest Amicus Br. 9-10. Although that same consulting firm now suggests that "[t]he Board's 2006 decision in *Baystate* really was the earliest clue to the regulated community that they *might* have been underpaid as a result of flaws in CMS's calculation of the SSI fraction," *id.* at 20, that firm and its clients necessarily had a "clue" many years prior.[4] And Baystate was

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and-comment rulemaking, 75 Fed. Reg. 50,275-50,286 (2010), and the Administrator directed that the revised matching process be applied to every "properly pending DSH appeal of the SSI fraction data matching process issue," HHS, CMS Ruling 1498-R, at 6, Apr. 28, 2010, http://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/CMS1498R.pdf.

[4] Many of the purported "facts" set forth by Southwest represent a disputed interpretation of the record in *Baystate* and not the findings by any administrative or judicial tribunal. See Gov't Mot. for Summ. J. at 29-44, *Baystate*, *supra* (No. 1:06-cv-1263) (explaining the alleged

not the first hospital to challenge the SSI fraction. In 1993, another hospital timely appealed seeking recalculation of its DSH adjustments based on its own independent calculation of the SSI fraction. See *Loma Linda Cmty. Hosp.* v. *Shalala*, 907 F. Supp. 1399, 1400-1402 (C.D. Cal. 1995).

Respondents, in contrast, allowed the statutory and regulatory deadlines to expire, and sat on the sidelines during seven years of administrative proceedings in *Baystate*. Only when that test case proved successful did respondents file piggyback appeals, more than a decade late.[5] The ease with which respondents (and nearly 200 other hospitals, Gov't Br. App. 34a-37a) now assert "fraud" and proclaim ignorance only further demonstrates why an equitable-tolling regime previously unknown to the Medicare provider appeals process would prove highly disruptive and burdensome. See *United States* v. *Brockamp*, 519 U.S. 347, 352 (1997);

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data errors and CMS's response and refuting "Baystate's contentions that agency employees repeatedly lied about the DSH calculations").

[5] The hospital provider community was well aware of issues regarding the SSI calculation throughout the pendency of the *Baystate* proceedings. See, *e.g.*, *Saint Mary's Mercy Med. Ctr.*, PRRB Dec. No. 2007-D63, 2007 WL 3341598, at *2 (Aug. 24, 2007) (in 2000, provider "undertook a review" of its SSI fraction "after questions arose in the hospital reimbursement community"); *St. Joseph Mercy Hosp.*, 2010 WL 5571062, at *3-*4 (CMS Adm'r Oct. 6, 2010) (provider challenged SSI calculation no later than March 2001 and appeal was placed in abeyance pending *Baystate*); John R. Jacob, *Hospitals Want Bigger Piece of Medicare Pie*, Nat'l L.J. (Aug. 30, 2004) ("hospitals have long believed that [SSI] percentages were improperly low" and "growing number of cases" pending before Board on that issue).

High Country Home Health, Inc. v. *Thompson*, 359 F.3d 1307, 1311 (10th Cir. 2004).[6]

2. Respondents repeatedly describe the regulatory regime, first adopted in 1974, as a "one-way ratchet" or a "one-way tolling rule." Br. 34, 50, 51, 55. Contrary to respondents' contention, however, the limited opportunities for additional administrative review after the expiration of 180 days are largely neutral.

The good-cause regulation, allowing limited extensions of the appeal deadline, inures only to the benefit of providers. The reopening regulation, for its part, is largely neutral. 42 C.F.R. 405.1885(a) (allowing reopening "on motion" of the intermediary, the Board, the Secretary, or the provider). Reopening may remedy underpayments or result in the recovery of overpayments. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 455-456 (1999) (*Your Home*). And while providers cannot seek discretionary reopening after three years, neither can the intermediary, the Board, or the Secretary. 42 C.F.R. 405.1885(a) ("No such determination or decision may be reopened after such 3-year period"); 42 C.F.R. 405.1885(b) (requiring reopening in certain circumstances if "within the 3-year period"). Thus, an intermediary determination or Board decision could not be reopened under the regulations after three years if the Secretary discovered that errors in calculating the SSI fraction had *overstated* hospitals' DSH payments. The opportunity for a hospital to seek an extension for taking an appeal for good cause, or to seek reopening, within three years is a manifestation of the Secretary's

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[6] Approximately 80% of the hospitals paid under the Prospective Payment System (PPS) receive DSH payments. See 77 Fed. Reg. 53,721-53,724 (2012) (3423 PPS hospitals, including 1903 urban and 820 rural DSH hospitals).

"grace," *Your Home*, 525 U.S. at 454, not a one-way ratchet—particularly not one that favors the Secretary.

The only example of the purported inequity that respondents identify is 42 C.F.R. 405.1885(d), which requires reopening "at any time if it is established that [the] determination or decision was procured by fraud or similar fault of any party to the determination or decision." The so-called "fraud" exception to the absolute three-year deadline for reopening is limited in scope and rarely used. CMS has taken the position that the term "established" requires an independent administrative or judicial finding of fraud or similar fault separate from any reopening, such as in a False Claims Act case. See, *e.g.*, Gov't Mot. to Dismiss or Summ. J. at 22, *Bradley Mem'l Hosp.* v. *Thompson*, 1:04-cv-416 Docket entry (D.D.C. July 30, 2004). A regulatory regime that allows the agency to recover overpayments in those circumstances based on fraud should not "shock[]" this Court, which was willing to countenance "a system in which underpayments could *never* be the basis for reopening." *Your Home*, 525 U.S. at 455.[7]

3. Respondents' insistence that somehow Congress promised them the payments they seek in this litigation, no matter how long after the fact, is equally unfounded. *E.g.*, Br. 57-58. When a provider chooses to participate in the Medicare program, its payments depend on the Medicare Act and the Secretary's implementing regulations, which require providers to comply with specified procedures in order to receive payment. A provider that

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[7] Contrary to respondents' contention (Br. 10, 50), the fraud exception applies equally to a fiscal intermediary if it "procured" a Board decision by "fraud or similar fault." A fiscal intermediary is a "part[y]" to the Board hearing, 42 C.F.R. 405.1843(a), even though it is not a "part[y]" to its own determination, 42 C.F.R. 405.1805.

fails to comply with those procedures is not entitled to payment any more than a taxpayer who fails to seek a refund within a specified period of time. Respondents' characterization of the payments allegedly due as "fully funded" and "set aside" by Congress, *id.* at 57, when the suit is based on cost reports that have been closed for a decade or more, blinks reality. Congress did not promise or set aside money to pay Medicare providers in 2012 for services rendered in 1987 in a case not appealed until 2006.

B. Respondents' Arguments For Ignoring Well-Established Principles of Administrative Law Are Unpersuasive

Respondents do not dispute that, through notice-and-comment rulemaking contemporaneous with the enactment of Section 1395*oo*(a)(3) nearly 40 years ago, the Secretary determined that the Board has no authority to hear appeals filed beyond the 180-day deadline, except as provided by regulation—*i.e.*, for good cause shown *if* the request is filed within three years of the NPR. Respondents also do not dispute that an equitable-tolling regime would conflict with the limitations in the Secretary's regulations. Respondents nevertheless contend that settled principles of administrative law precluding courts from imposing extra-statutory procedural requirements on an administrative tribunal, see *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978) (*Vermont Yankee*), and from setting aside a duly promulgated regulation that is neither arbitrary nor capricious, should not apply here. Respondents fail to confront the force of this Court's precedents.

1. The government's opening brief argues at length (Br. 17-29) that *Vermont Yankee* prohibits courts from unilaterally imposing on agencies additional procedural rules not required by statute, and that the equitable-

tolling regime adopted by the court of appeals here would do precisely that. Respondents devote three paragraphs to arguing that *Vermont Yankee* is "inapt." Br. 54-55. Contrary to respondents' suggestion, *Vermont Yankee* is not limited to an agency's rulemaking procedures, nor to an analysis of the procedures imposed by the Administrative Procedure Act (APA). See *Pension Benefit Guar. Corp.* v. *LTV Corp.*, 496 U.S. 633, 653-656 (1990) (applying *Vermont Yankee* to informal agency adjudication where no provision in governing statute or APA afforded asserted procedural rights). Rather, as this Court explained in *Vermont Yankee*, "[e]ven apart from the [APA] this Court has for more than four decades emphasized that the formulation of procedures was basically to be left within the discretion of the agencies to which Congress had confided the responsibility for substantive judgments." 435 U.S. at 524; see *FCC* v. *Pottsville Broad. Co.*, 309 U.S. 134, 143 (1940).

2. Respondents make no attempt to argue that the Secretary's good-cause regulation for an extension of the appeal deadline, including the three-year outer limit, is arbitrary or capricious. Gov't Br. 29-31. Neither do respondents dispute that the good-cause regulation falls squarely within the Secretary's broad rulemaking authority. *Id.* at 18. Respondents do contend (Br. 54) that Congress would not have delegated authority to the Secretary to avoid performing administrative review required by Congress, but the substance of respondents' objection is not clear. If they are suggesting that the Secretary has no authority to interpret the Board's adjudicatory jurisdiction, the Court held otherwise in *Your Home*. Gov't Br. 50-51; *id.* at 49-50 (citing cases). If they are merely suggesting that the Secretary has no authority to reject open-ended equitable tolling because

in their view Congress mandated it, their nondelegation argument collapses into a question of statutory interpretation. See Part C, *infra*. On its face, Section 1395*oo*(a)(3) provides for Board review only "*if*," among other things, the provider files a hearing request within 180 days. 42 U.S.C. 1395*oo*(a)(3) (emphasis added). If there were any conflict between the good-cause regulation and the plain language of the statute, it would be with the Secretary's allowance of *any* extension of the 180-day period, not her failure to adopt an amorphous equitable-tolling regime that has had no place in the Medicare provider payment program for the entire history of its existence. See Court-Appointed Amicus Br. 41-47.

C. Congress Did Not Mandate Open-Ended Equitable Tolling Of The 180-Day Appeal Period

Respondents argue that *Chevron* deference is not warranted because Section 1395*oo*(a)(3) is not ambiguous. Br. 51-52. That argument rests not on the statutory text, which says nothing about equitable tolling, or on generally applicable tools of statutory interpretation. Instead, respondents rely exclusively on the presumption in favor of equitable tolling that this Court adopted in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), for a statute of limitations applicable to suits filed in court. See Br. 52 ("[A]pplication of the presumption eliminates any ambiguity for the agency to interpret."). No such presumption applies here. But even if a presumption applied in some form, the Secretary's implementation of Section 1395*oo*(a)(3) is sound and respondents cannot prevail.

1. a. This Court has never applied the *Irwin* presumption to impose equitable tolling on internal agency review procedures. Gov't Br. 32-36. Neither case cited

by respondents (Br. 44) applied a presumption and each is inapposite for other reasons. The government's opening brief (Br. 33-34) explains in detail why *Zipes* v. *Trans World Airlines, Inc.*, 455 U.S. 385 (1982), is readily distinguishable. *Union Pacific R.R.* v. *Sheehan*, 439 U.S. 89, 92 (1978) (per curiam), is even further removed because the Court did nothing more than explain that, as a matter of fact, the National Railroad Adjustment Board *had* considered the railroad employee's claim that the applicable time deadline (in a collective-bargaining agreement) should be equitably tolled.

Respondents contend that it would "make[] little sense" to forgo a "statutory analysis" where "the time period at issue" is "for administrative, rather than judicial, review." Br. 42. That misapprehends the government's argument. If Congress intends a statutory time limit to be subject to equitable tolling, that intent of course controls. Before its decision in *Irwin*, the Court used traditional tools of statutory interpretation to determine whether equitable tolling of a suit-filing time limit implicating the Federal Treasury would be "consistent with Congress' intent," *Bowen* v. *City of N.Y.*, 476 U.S. 467, 480 (1986). Gov't Br. 40-41. In the administrative context, traditional tools of statutory construction entail application of the rules governing judicial review of an agency action or interpretation, which are drawn from the APA, *Chevron*, and *Vermont Yankee*. Where Congress has expressly granted authority to an agency to promulgate rules and procedures to govern the administrative appeals process, it makes "little sense" (Resp. Br. 42) to *presume* that Congress intended the Judiciary to adopt freestanding equitable exceptions to statutory and regulatory deadlines and other prerequisites to internal administrative review. Far

from "a realistic assessment of legislative intent," *id.* at 42 (quoting *Irwin*, 498 U.S. at 95), incantation of a presumption would redistribute the authority granted by Congress from the expert agency to the courts. See *Pottsville Broad.*, 309 U.S. at 144 (cautioning against reading "the laws of Congress through the distorting lenses of inapplicable legal doctrine"); *id.* at 141 ("[T]o the extent that a federal court is authorized to review an administrative act, there is superimposed upon the enforcement of legislative policy through administrative control a different process from that out of which the administrative action under review ensued.").

For these reasons, respondents' assertion that "equitable tolling by an agency adjudicator" is "the rule, not the exception," Br. 43, proves very little. There are many instances in which the administering agency *agrees* that equitable tolling should be available, or that some other exception to finality should be allowed, at least in certain circumstances. Indeed, here, the Secretary has done so by adopting the regulations allowing reopening and extension of the appeal deadline, subject to the three-year limitation. There may also be instances in which the administering agency has declined to allow equitable tolling, but a contrary congressional intent is clear. A presumption in favor of equitable tolling is not needed to identify those cases.[8]

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[8] The courts of appeals cases cited by respondents (Br. 43 n.16) are distinguishable. *Jackson* v. *Astrue*, 506 F.3d 1349, 1352-1353 (11th Cir. 2007), did not involve an administrative deadline, but rather the same judicial review deadline at issue in *City of New York*. In several other cases, the administering agency agreed that equitable tolling was available. *Hill* v. *Merit Sys. Prot. Bd.*, No. 2012-3024, 2012 WL 1663002, at *3 (Fed. Cir. May 14, 2012) (discussing equitable tolling of administrative complaint deadline which government conceded was available in prior case, see *Kirkendall* v. *Department of Army*, 479

b. To the extent respondents argue that this Court can apply *Irwin*'s presumption without identifying a "precise private equivalent," Resp. Br. 45-46, the government does not disagree, Gov't Br. 38. But respondents' reliance on *Holland* v. *Florida*, 130 S. Ct. 2549, 2560-2562 (2010), to suggest that they need not identify *any* private analogue is misplaced. As the government explains in its opening brief (Br. 39 & n.18), *Holland*, a state habeas corpus case, did not require the Court to identify any private analogue because habeas (quite unlike statutory payments under Medicare) has historically been governed by equitable principles, and because *Holland* was not a suit against the United States, let alone one implicating the heightened sovereign-immunity principles that govern when a party seeks money from the Federal Treasury. Respondents also cite *City of New York*, 476 U.S. at 480, and *Honda* v. *Clark*, 386 U.S. 484, 500-501 (1967), but *Honda* did not

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F.3d 830, 837 (Fed. Cir.) (en banc), cert. denied, 552 U.S. 948 (2007)); *Ajalla* v. *White*, 81 Fed. Appx. 715, 719 (10th Cir. 2003) (29 C.F.R. 1614.604(c) expressly provides for equitable tolling of regulatory deadline); *Von Eye* v. *United States*, 92 F.3d 681, 684 (8th Cir. 1996); *White* v. *Bentsen*, 31 F.3d 474, 475 (7th Cir. 1994), cert. denied, 514 U.S. 1050 (1995); *School Dist. of Allentown* v. *Marshall*, 657 F.2d 16, 18-19 (3d Cir. 1981); cf. *Ramirez* v. *Secretary*, 686 F.3d 1239, 1243 (11th Cir. 2012) (regulation provides for mandatory extension in specified circumstances). In one case where the government argued that equitable tolling was unavailable, the defendant agency did not ask for deference in the court of appeals. *Kirkendall*, 479 F.3d at 836-844 (veterans discrimination appeal). The other two cases involved time limits for motions to reopen immigration removal proceedings. *Albillo-De Leon* v. *Gonzales*, 410 F.3d 1090, 1095-1098 (9th Cir. 2005); *Iavorski* v. *INS*, 232 F.3d 124, 129-134 (2d Cir. 2000) (Sotomayor, J.). The reopening statutes and regulations there, however, have been read by some courts to suggest flexibility, *e.g.*, *id.* at 130-132, and removal proceedings do not involve sophisticated institutional litigants.

involve payments from the general Treasury, and both decisions predated *Irwin* and therefore looked to congressional intent without applying any presumption in favor of equitable tolling.

c. If a presumption in favor of equitable tolling were to apply at all in this context, it would be substantially weakened because equitable principles have not traditionally governed Medicare provider payments, and because the 180-day administrative appeal period was enacted 18 years before this Court's decision in *Irwin*. Gov't Br. 39-40. Respondents' answer is to describe the Board's powers as "flexible." Br. 46. But the only "flexibility" respondents point to is expressly set forth by statute; the Board does not have any inherent equitable powers outside those prescribed by the Medicare Act and the Secretary's implementing regulations. Gov't Br. 20-22.

2. Even if the *Irwin* presumption had some application, there are "good reason[s] to believe that Congress did *not* want the equitable tolling doctrine to apply[.]" *Brockamp*, 519 U.S. at 350.

a. For nearly 40 years, the Secretary has prohibited the Board from extending the 180-day deadline, except as provided by regulation. Until the decision below, no court had ever superimposed equitable-tolling principles onto that statutory and regulatory scheme. Against that backdrop, Congress amended Section 1395*oo* on six separate occasions and never expressed any disapproval of the Secretary's interpretation. Gov't Br. 20 & n.8. "It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the 'congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended

by Congress.'" *CFTC* v. *Schor*, 478 U.S. 833, 845-846 (1986) (citation omitted).

Respondents do not dispute any of this history. Indeed, they rely on it to argue that the 180-day administrative appeal deadline is not jurisdictional. Resp. Br. 17-18, 34. According to respondents, "for nearly four decades, the Secretary has treated Section 1395*oo*(a)(3)'s time limit as nonjurisdictional" and "Congress's longstanding acceptance of (a)(3)'s nonjurisdictional status merits * * * respect." Br. 34.[9] It is true that the Secretary has not treated Section 1395*oo*(a)(3)'s time limit itself as "jurisdictional" in the sense that she could not allow for any extension by regulation. But from the outset the Secretary has imposed strict limitations on such extensions. Congress's longstanding acceptance of the Secretary's treatment of Section 1395*oo*(a)(3) thus necessarily includes acceptance of those strict limitations, which are incompatible with the equitable tolling respondents seek.

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[9] Respondents contend that "for nearly forty years, most courts and the Executive Branch's published regulations have treated" the 180-day limit "as nonjurisdictional and subject to equitable exceptions." Br. 23 n.6. That is incorrect. First, two of the three courts of appeals to consider the issue concluded that the time limit *is* jurisdictional in the strictest sense and that even the Secretary's regulation allowing extensions for good cause is invalid. Compare *St. Joseph's Hosp.* v. *Heckler*, 786 F.2d 848, 851-853 (8th Cir. 1986), and *Alacare Home Health Servs., Inc.* v. *Sullivan*, 891 F.2d 850, 856 (11th Cir. 1990), with *Western Med. Enters.* v. *Heckler*, 783 F.2d 1376, 1379-1380 (9th Cir. 1986). Second, during that 40-year time frame, *no* court ever recognized an "equitable" exception to the statutory and regulatory appeal deadline. Third, the Secretary's "published regulations" likewise never recognized any "equitable" exceptions. See pp. 19-20, *infra*.

b. Nothing about the 60-day deadline set forth in 42 U.S.C. 1395*oo*(f)(1) for seeking *judicial* review suggests otherwise. Resp. Br. 41-42. Even assuming that time limit is subject to equitable tolling,[10] it does not follow that the administrative time limit for seeking Board review must also be subject to tolling that the Secretary's regulations do not allow. A provider is entitled to judicial review only if it has satisfied the statutory preconditions, which include securing a "final decision of the Board." 42 U.S.C. 1395*oo*(f)(1). As relevant here, a provider may obtain a hearing before the Board (and, thus, a final decision) only if "such provider" is dissatisfied with the intermediary's payment determination; the amount in controversy is $10,000 or more; and the request is filed within 180 days. 42 U.S.C. 1395*oo*(a). Pursuant to that statutory scheme, if the provider is not "dissatisfied," or if the amount in controversy is less than $10,000, the provider is not entitled to any judicial review of the intermediary's determination. The same is true of a provider who fails to file a hearing request within the period specified by Section 1395*oo*(a) and the Secretary's regulations.

There is another, more practical reason to distinguish the judicial review deadline in Section 1395*oo*(f)(1) from the administrative appeal deadline in Section

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[10] The Secretary has argued that the 60-day judicial review period in Section 1395*oo*(f)(1) is not subject to equitable exceptions. The courts have reached different conclusions. Compare *Lloyd Noland Hosp. & Clinic* v. *Heckler*, 762 F.2d 1561, 1564-1565 (11th Cir. 1985) (subject to waiver and equitable tolling), and *Bedford Cnty. Mem'l Hosp.* v. *Heckler*, 583 F. Supp. 367, 370-371 (W.D. Va. 1984) (subject to waiver), aff'd, 769 F.2d 1017 (4th Cir. 1985), with *Wilmac Corp.* v. *Thompson*, No. 03-5936, 2007 WL 2599238, at *2-*3 (E.D. Pa. Sept. 4, 2007) (not subject to equitable tolling), and *Kidney Ctr.* v. *Shalala*, 63 F. Supp. 2d 51, 55-57 (D.D.C. 1999) (not subject to waiver).

1395*oo*(a)(3). The universe of reasons for invoking equitable tolling of the 60-day judicial review deadline would be quite limited. Once a provider has "notice" that a final administrative decision has issued, 42 U.S.C. 1395*oo*(f)(1), it would be exceedingly difficult to assert a justification for missing the filing deadline, especially more than a few days or weeks. The limited case law touching on equitable tolling of the 60-day deadline, see note 10, *supra*, bears that out. By contrast, as amply demonstrated by this case and the other related cases pending in district court, Gov't Br. App. 34a-37a, the same cannot be said of the 180-day administrative appeal deadline. Superimposing an open-ended equitable tolling regime onto the carefully structured administrative review process would deprive closed payment determinations from many years earlier of the finality they have long enjoyed, and would place substantial administrative burdens on the agency, its contractors, and the Medicare Trust Fund, Gov't Br. 23-28, in a way that equitable tolling of the judicial review deadline would (and has) not. Even if Congress intended the latter, it would not have envisioned (let alone mandated) the former. Simply put, the program could not function with any degree of efficiency without the order and finality achieved through the statutory and regulatory regime that has long governed the administrative review process.

c. Respondents' attempts to minimize the importance of administrative finality and the practical effects of an equitable-tolling regime are unavailing.

Respondents first contend (Br. 47-48) that the Board is perfectly capable of engaging in a fact-intensive equitable tolling inquiry and, indeed, has been "regularly" engaging in "equitable inquiries." Respondents conflate the Secretary's focused good-cause regulation with the

open-ended equitable tolling regime they urge.[11] The good-cause regulation is substantially more limited than judicially imposed equitable tolling. Most significantly, like the reopening regulation, it has a mandatory three-year outer limit. Respondents barely acknowledge that critical distinction. There is a world of difference between the possibility that a past cost year may be revisited within three years of the intermediary's determination, but no later, and the possibility that a past cost year may be revisited *at any time*. Moreover, while equitable tolling is itself a narrow doctrine, it is still broader than the Secretary's limited good-cause exception to the 180-day appeal deadline—particularly after the 2008 regulatory amendments. 73 Fed. Reg. 30,206 (2008); 42 C.F.R. 405.1836(b) (2011) (limiting good cause to "extraordinary circumstances beyond [the hospital's] control (such as a natural or other catastrophe, fire, or

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[11] Only four of the cases respondents cite discuss equitable tolling. Two involved the same *Baystate* issue presented here. In those cases, the Board, after holding that equitable tolling is unavailable as a matter of law, briefly explained that, even if tolling were available, it would not be warranted based on the "undisputed facts." *Medical Coll. of Ga. Hosp.*, 2010 WL 4214223, at *3; *SKI 1987-1994 DSH SSI% Group*, PRRB Dec. No. 2009-D12, 2009 WL 981317, at *4 (Mar. 5, 2009). The other two cases did not involve the 180-day appeal deadline at issue here, and any analysis of equitable principles was cursory at best. See *Bradford Reg'l Med. Ctr.*, PRRB Dec. No. 99-D19, 1999 WL 10149, at *8 (Jan. 7, 1999) (90-day period for submitting supporting documentation relating to capital-related costs), rev'd, 1999 WL 398034 (HCFA Adm'r Mar. 12, 1999), rev'd, *Bradford Hosp.* v. *Shalala*, 136 F. Supp. 2d 428 (W.D. Pa. 2001); *New Hanover Reg'l Med. Ctr. & Psychiatric Unit*, PRRB Dec. No. 2003-D37, 2003 WL 21804275, at *6 (July 17, 2003) (180-day period for requesting adjustment to rate-of-increase ceiling). The equitable-tolling inquiry respondents advocate would in fact be a drastic departure from the Board's "regular[]" practice that has endured for nearly 40 years.

strike)"). Accordingly, application of the good-cause exception does not require the agency to devote significant resources to adjudicating untimely appeals. Gov't Br. 24.

Respondents also contend that no "floodgates" would open because equitable-tolling claims would be limited to "the agency's own misfeasance," which is "entirely within the Secretary's own control." Br. 55-56. That equitable-tolling relief should rarely be *granted*, however, does not mean that the doctrine would rarely be invoked. Recent history shows that what constitutes "misfeasance" is in the eye of the beholder. Gov't Br. 25-27. As this Court recognized in *Brockamp*, the mere availability of equitable tolling "could create serious administrative problems by forcing the [agency] to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for 'equitable tolling' which, upon close inspection, might turn out to lack sufficient equitable justification." 519 U.S. at 352; see *High Country*, 359 F.3d at 1311 ("[F]or every plaintiff whose substantive claim or reason for default leads an adjudicator to excuse the default, ten less sympathetic plaintiffs are likely to demand similar treatment.").

The Medicare Act's "complex and highly technical regulatory program" heightens the need for finality. *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (citation omitted); see *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1235 (D.C. Cir. 1994) ("policy of retroactive corrections would erode the predictability and finality that underlie the [Medicare Prospective Payment System] scheme"). This Court recognized in *Your Home* that "the statutory purpose of imposing a 180-day limit on the right to seek Board review of NPRs * * * would be frustrated by permitting requests to reopen to be re-

viewed indefinitely." 525 U.S. at 454. Engrafting an open-ended equitable tolling regime onto Section 1395*oo*(a)(3) would have an even more dramatic effect, because it would not be cabined by a three-year outer limit. Contrary to respondents' assertion (Br. 39 n.13), the need for order and finality under Medicare is especially critical in light of the backlog of cases before the Board. Gov't Br. 30-31. "[T]he Board is burdened by an immense caseload," and "procedural rules requiring timely filings are indispensible devices for keeping the machinery of the reimbursement appeals process running smoothly." *High Country*, 359 F.3d at 1310.[12]

D. The Board Has No Authority To Adjudicate Appeals Filed Outside The Statutory And Regulatory Deadlines

Respondents contend (Br. 34) that the government agrees that Section 1395*oo*(a)(3) is not jurisdictional. What the government explains in its opening brief, however, is that although Section 1395*oo*(a)(3) does limit the Board's jurisdiction, it does not preclude the Secretary from adopting a narrow and time-limited good cause exception to the 180-day filing deadline, in the exercise of her broad authority under the Medicare Act. Section

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[12] Respondents compare the size of the Medicare program to that of Social Security, Br. 49 n.19, but there are at least two critical distinctions. First, the disability benefits scheme at issue in *City of New York* was "designed to be 'unusually protective' of claimants," 476 U.S. at 480, whereas the Medicare payment scheme at issue here involves "sophisticated" institutional providers, *Your Home*, 525 U.S. at 456. Second, a determination of individual entitlement to disability benefits does not have the breadth and technical complexity involved in a determination of Medicare provider payments. In that respect, Medicare provider payments are more analogous to the subject matter in *Brockamp* (tax collection) than to the subject matter in *City of New York* (Social Security disability benefits).

1395*oo*(a)(3) and the regulations implementing it then *together* establish mandatory time limits on the Board's adjudicative authority. The court of appeals erred in overriding those mandatory limits by imposing an unprecedented open-ended equitable tolling regime on the Medicare provider appeals process that Congress enacted 40 years ago.

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For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General

NOVEMBER 2012

AMICUS CURIAE BRIEF

RECORD AND BRIEFS

No. 11-1231

IN THE
Supreme Court of the United States

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF FOR COURT-APPOINTED *AMICUS CURIAE* SUPPORTING REVERSAL

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QUESTION PRESENTED

May the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, *see* 42 U.S.C. § 1395*oo*(a)(3), be extended for any period?

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INTEREST OF *AMICUS CURIAE*

On July 23, 2012, this Court invited John F. Manning "to brief and argue this case, as *amicus curiae*, in support of the position that the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. §1395*oo*(a)(3), may not be extended for any period." This brief responds to that invitation.[1]

STATEMENT

A. Statutory and Regulatory Background

1. The Medicare Act, Title XVIII of the Social Security Act, as amended, 42 U.S.C. § 1395 *et seq.*, provides medical services for elderly and disabled patients. Part A of the program prescribes that, when certain classes of health care providers supply covered health services to Medicare beneficiaries, they receive reimbursements for certain costs as determined by statute and by regulations promulgated by the Secretary of Health and Human Services ("HHS"). *See id.* § 1395c *et seq.* Since 1983, the Medicare statute has provided that, for in-patient hospital services, providers will receive reimbursement under a "prospective payment system" that sets a standardized rate for each discharge based on the patient's diagnosis-related group ("DRG"), which is calculated on the basis of, among other things, the patient's diagnosis, age, and sex. *See id.* § 1395ww(b), (d); *see also Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 406 n.3 (1993). Because the

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[1] No counsel for a party authored any part of this brief, and no person other than *amicus*, his co-counsel, and his employer (Harvard University) made any financial or other material contribution to the preparation of this brief.

amount of reimbursement reflects a prospectively determined average that does not necessarily capture actual costs, the statute directs the Secretary to make certain adjustments based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5).

2. To obtain Medicare reimbursements, health care providers must submit "cost reports" annually to fiscal intermediaries (typically, insurance companies) that the Secretary has designated to calculate reimbursements under applicable statutory and regulatory criteria. *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 405.1801(b), 413.20(b), 413.24(f), 421.3;[2] *see also Regions Hosp. v. Shalala*, 522 U.S. 448, 452 (1998). The intermediary then analyzes the cost report, audits it if necessary, and issues a "notice of amount of program reimbursement" ("NPR") specifying the provider's reimbursement for the fiscal year covered by the report. 42 C.F.R. § 405.1803; *see Regions Hosp.*, 522 U.S. at 452-53.

3. In the early years of the Medicare program, the statute provided no mechanism for further review of an intermediary's reimbursement determination, and, while the Department of Health, Education, and Welfare had sought to develop administrative procedures to settle disputes between providers and intermediaries, the House Ways and Means Commit-

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[2] Unless otherwise indicated, this brief will refer to the 2007 edition of 42 C.F.R. Although Part 405 of 42 C.F.R.—including some of the sections at issue in this litigation—was subsequently amended, the amendments themselves specify that, with exceptions not applicable here, the changes apply only to "appeals pending as of, or filed on or after[,] August 21, 2008." 73 Fed. Reg. 30,190, 30,190 (May 23, 2008). The amended regulations, therefore, do not govern this case. *See* Pet. App. 15a n.3.

tee thought it necessary to establish "a specific procedure for settling disputed final determinations applying to the amount of program reimbursement." H.R. Rep. No. 92-231, at 108 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5094. To that end, the Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1329, 1420, established the Provider Reimbursement Review Board ("PRRB" or "Board") and put in place a detailed scheme of administrative and judicial review for intermediaries' final determinations of cost reimbursements.

The statute—42 U.S.C. § 1395*oo*[3]—establishes the Board, prescribes its powers, and sets forth the mechanism for judicial review of the Board's decisions. Subsection (a), captioned "Establishment," delineates what cases the newly established Board may hear. First, as to subject matter, a provider that has filed timely cost reports may seek review if it is "dissatisfied" with an intermediary's determination of cost reimbursements or with the Secretary's determination of the "amount of the payment" to be received during a fiscal year under the prospective payment system. *Id.* § 1395*oo*(a)(1)(A)(i), (ii).[4] The Board may also hear the case if the provider has not received an amount determination from the Secretary or an NPR from the intermediary on "a timely basis" after having filed the necessary materials in conformity with applicable regulations. *Id.* § 1395*oo*(a)(1)(B), (C). Second, the right to a hearing accrues only if "the amount in controversy is $10,000 or more." *Id.*

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[3] The text of § 1395*oo* is set forth in the Addendum to the brief.

[4] Because respondents challenge calculations embodied in their NPRs, *see* Pet. App. 17a, their challenge arises under subsection (a)(1)(A)(i).

§ 1395*oo*(a)(2). Third, a provider may seek a hearing only if "such provider files a request for a hearing within 180 days" after notice of the intermediary's or the Secretary's "final determination" or, for claims of unlawfully delayed determination, "within 180 days after notice of such determination would have been received if such determination had been made on a timely basis." *Id.* § 1395*oo*(a)(3).

The balance of § 1395*oo* fleshes out the review scheme. Providers, for example, "have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses," and Board decisions must be "upon the record." *Id.* § 1395*oo*(c), (d). The Board has the power "to affirm, modify, or reverse" the fiscal intermediary's "final determination" and "to make any other revisions on matters covered by [the provider's] cost report," whether or not the intermediary considered those matters in rendering an NPR. *Id.* § 1395*oo*(d). The Board's decision becomes final within 60 days unless the Secretary, "on [her] own motion," decides to "reverse[], affirm[], or modif[y]" it. *Id.* § 1395*oo*(f)(1).[5] A provider may then file a civil action in district court within 60 days of receiving notice of the Board's final decision or, if the Secretary acts, of her final disposition of the matter. *Id.*

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[5] The Secretary delegated her authority to review the Board's decisions to the Administrator of the Health Care Financing Administration ("HCFA"). *See* 49 Fed. Reg. 35,247, 35,248 (Sept. 6, 1984). In 2001, the Secretary changed HCFA's name to the Center for Medicare & Medicaid Services ("CMS") and redelegated to the CMS Administrator all authority previously delegated to the HCFA Administrator. *See* 66 Fed. Reg. 35,437 (July 5, 2001). For simplicity, this brief will refer to HCFA and CMS as CMS.

4. In regulations promulgated pursuant to express authority to implement the Medicare program, *see* 42 U.S.C. §§ 1302(a), 1395*l*(a), 1395hh(a)(1), the Secretary has added further detail to the review scheme established by the statute. *See, e.g.*, 42 C.F.R. §§ 405.1835 ("Right to Board hearing."), 405.1837 ("Group appeal."), 405.1839 ("Amount in controversy."). At all times relevant here, HHS regulations gave the Board discretion to extend the 180-day time limit "for good cause shown," provided that the request for extension was filed not "more than 3 years after the date the notice of the intermediary's determination [was] mailed to the provider." *Id.* § 405.1841(b).[6]

B. Statement of the Case

1. This case arises from respondents' claims for additional reimbursements for fiscal years 1987 through 1994. *See* Pet. App. 2a. The Medicare Act provides for additional payments to "disproportionate share hospitals" ("DSH")—those which "serve[] a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). The

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[6] The 2008 amendments to Part 405 of 42 C.F.R. tightened up the requirements for extension of time. Under the current regulations, "[t]he Board may find good cause . . . only if the provider demonstrates . . . [that] it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike)." 42 C.F.R. § 405.1836(b) (2011). The Board must receive the request for extension "within a reasonable time" after the 180-day limit expires, but no "later than 3 years after" the NPR issues. *Id.* § 405.1836(b), (c)(2). Finally, the amended regulation precludes the Board from granting an extension where the request is based on "a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy." *Id.* § 405.1836(c)(1).

DSH provision at issue here states that, for any given hospital, the DSH adjustment for a fiscal year depends on the number of patient-days spent by patients entitled to both Medicare Part A *and* Supplemental Security Income ("SSI") benefits, divided by the number of patient-days spent by those entitled to Medicare Part A benefits. *See id.* § 1395ww(d)(5)(F)(vi)(I).[7] The Center for Medicare & Medicaid Services ("CMS") calculates the so-called "Medicare/SSI fraction" for each hospital each fiscal year and supplies that number to the fiscal intermediary, which then calculates the disproportionate patient percentage and makes an appropriate DSH adjustment to the reimbursement. *See* 42 C.F.R. § 412.106(b).

2. After receiving NPRs in the years at issue, respondents did not appeal their DSH adjustments to the PRRB within the 180-day limit prescribed by 42 U.S.C. § 1395*oo*(a)(3). *See* Pet. App. 17a. Rather, respondents' lawsuit grew out of information revealed in unrelated litigation by Baystate Medical Center ("Baystate"). *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *amended in part*, 587 F. Supp. 2d 37 (D.D.C. 2008). In a timely appeal by Baystate of its DSH adjustments for fiscal years 1993 through 1996, the Board found that CMS had omitted several categories of SSI eligibility data and used a flawed method of identifying SSI-eligible Medicare patients. *See* Pet. App. 17a-18a. Although CMS then reversed the Board's determination, the district court in *Bay-*

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[7] A second DSH adjustment reflects the proportion of patient-days spent by patients entitled to Medicaid divided by the total number of patient-days. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The Medicaid-based adjustment is not at issue in this case.

state reversed CMS and largely affirmed the Board's determinations. *See id.* at 18a n.5.

3. On September 12, 2006, approximately three months after the Board's *Baystate* decision, respondents sought Board review of their DSH adjustments for fiscal years 1987 to 1994. *See* Pet. App. 2a, 18a. They conceded that their appeals were filed outside both the 180-day limit set by 42 U.S.C. § 1395*oo*(a)(3) and the three-year period within which they could have sought a "good cause" exception to that limit under 42 C.F.R. § 405.1841(b). *See* Pet. App. 18a. Respondents argued, however, that, in light of "CMS' alleged knowing and unlawful refusal to inform hospitals that the SSI percentage was incorrectly stated for the fiscal years under appeal," their case qualified for equitable tolling. *Id.* at 53a.

The Board held that it "lack[ed] jurisdiction" over respondents' appeal for the years in question because it "was not timely filed." *Id.* at 55a. Citing *Anaheim Memorial Hospital v. Blue Cross of California*, PRRB Dec. 2000-D72 (Medicare and Medicaid Guide (CCH)) ¶ 80,527 (PRRB July 3, 2000), the Board reasoned that "it does not have general equitable powers and cannot grant equitable relief such as equitable tolling." Pet. App. 55a. Rather, as "an administrative forum," it possesses "only the powers granted to it by statute and regulation." *Id.* Accordingly, the Board concluded that it had no power to hear an appeal not filed within either the statutory 180-day limit or the three-year regulatory window in which to seek a "good cause" exception. *Id.*

4. Respondents filed the present action challenging the Board's decision in the U.S. District Court for the District of Columbia. *See* Pet. App. 11a-50a.

Invoking *Irwin v. Department of Veterans Affairs*, 498 U.S. 89 (1990), respondents argued that the time limit prescribed by § 1395*oo*(a)(3) was presumptively subject to equitable tolling. Pet. App. 30a. The court, however, found that the *Irwin* presumption applies only when a suit against the federal government is analogous to a private lawsuit for which equitable tolling would be available. *Id.* at 31a. Reasoning that "the programmatic reimbursement at issue is not familiar to private litigation," the court found the *Irwin* presumption inapplicable. *Id.* at 32a.

The district court further relied on *United States v. Brockamp*, 519 U.S. 347 (1997), which had held that the emphatic language and complexity of the limitations period for tax-refund claims, *see* 26 U.S.C. § 6511, showed that Congress did not intend to supplement the statute with judge-made equitable tolling. The court reasoned that the Medicare Act also expressed the 180-day limit in "'emphatic' language." Pet. App. 34a. And, while acknowledging that the PRRB review scheme was not as intricate as the tax scheme at issue in *Brockamp*, the court found it significant that the Secretary had used her delegated rulemaking authority to supplement the statute's time limit with rules specifying the circumstances in which a late filing would be excused or a final Board determination reopened. *Id.* at 36a-37a. The court held that, if it were to apply a judge-made equitable tolling doctrine, it would circumvent the Secretary's careful regulatory scheme. *Id.* at 39a-40a. Finally, while resting on the previously discussed grounds, the court added that "[t]he volume and complexity of the provider reimbursement program" and the sophistication of Medicare providers

at least "buttressed" its conclusion that Congress did not intend to permit equitable tolling. *Id.* at 40a.

5. The D.C. Circuit reversed. Pet. App. 1a-10a. The court of appeals reasoned that the presumption in favor of equitable tolling applies with full force to the PRRB review scheme. The court noted that the language of § 1395*oo*(a)(3) is no more emphatic than that of other time limits that the courts had subjected to equitable tolling. *Id.* at 7a. Further, distinguishing the PRRB review scheme from the tax statute at issue in *Brockamp*, the court emphasized that the latter scheme not only speaks in "'highly detailed'" and "'technical'" terms, but also "'sets forth explicit exceptions to its basic time limits.'" *Id.* at 7a-8a (quoting *Brockamp*, 519 U.S. at 350, 351). In contrast, § 1395*oo*(a)(3)'s time limit is stated in relatively simple terms. *See id.* at 9a. In addition, because the elaborate exceptions to § 1395*oo*(a)(3)'s 180-day time limit appear in agency regulations rather than the statute, the court concluded that they shed no light on congressional intent. *Id.* In short, the court of appeals concluded that, while the provider review scheme is complex, "unlike the tax code, [it] does not create a detailed Jenga tower of deadlines and exceptions that equitable tolling might topple." *Id.* at 10a.

6. The court of appeals' decision brought the D.C. Circuit into conflict with the Eleventh Circuit's decision in *Alacare Home Health Services, Inc. v. Sullivan*, 891 F.2d 850 (11th Cir. 1990), and the Eighth Circuit's decision in *St. Joseph's Hospital v. Heckler*, 786 F.2d 848 (8th Cir. 1986). Both circuits held that § 1395*oo*(a)(3)'s 180-day limit is jurisdictional and therefore not subject to any unspecified exception. Those courts reasoned that the statutory

text set forth clear and unqualified limits on the Board's authority and that the legislative history reinforced the mandatory character of that limitation. *See Alacare*, 891 F.2d at 856; *St. Joseph's*, 786 F.2d at 851-52. Under that reasoning, § 1395*oo*(a)(3)'s time limit is subject neither to equitable tolling by the judiciary nor to the Secretary's regulatory "good cause" exception. *See Alacare*, 891 F.2d at 856. The Ninth Circuit, in contrast, held that the Secretary's "good cause" exception represented a permissible interpretation of § 1395*oo*(a)(3) and was therefore entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *See Western Med. Enters., Inc. v. Heckler*, 783 F.2d 1376, 1379-80 (9th Cir. 1986).

SUMMARY OF ARGUMENT

Congress prescribed an unqualified 180-day limit for sophisticated Medicare providers to challenge a reimbursement decision before the Provider Reimbursement Review Board. *See* 42 U.S.C. § 1395*oo*(a). Like other procedural requirements, time limits can qualify as jurisdictional rules or as claims-processing rules. Because a jurisdictional limitation defines the authority of a tribunal to act, this Court has traditionally held that such limitations are not subject to waiver, forfeiture, or (in the case of time limitations) equitable tolling. *See, e.g., Gonzalez v. Thaler*, 132 S. Ct. 641, 648 (2012); *Dolan v. United States*, 130 S. Ct. 2533, 2538 (2010). Because claims-processing rules merely facilitate the orderly progress of litigation, they permit greater flexibility on all of those dimensions. *See, e.g., Henderson v. Shinseki*, 131 S. Ct. 1197, 1203 (2011). Congress alone has the power to determine whether a procedural requirement constitutes a strict "jurisdictional" rule or a more flexible

"claims-processing rule." *See, e.g., id.*; *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 514-15 (2006). Because jurisdictional rules and claims-processing rules may possess similar qualities, identifying the distinction between them can be "confusing in practice." *Reed Elsevier, Inc. v. Muchnick*, 130 S. Ct. 1237, 1243 (2010). Accordingly, this Court has sought to clarify the inquiry by treating procedural requirements as presumptively nonjurisdictional in the absence of a "clear" legislative indication to the contrary. *Henderson*, 131 S. Ct. at 1203. In this case, the text and structure of § 1395*oo*(a) and that provision's relationship to the Medicare Act as a whole clearly indicate that subsection (a)(3)'s timely filing requirement is jurisdictional.

A. This Court has explained that a jurisdictional provision "delineat[es] the class of cases" that a tribunal has the authority to hear and "the persons . . . falling within [its] adjudicatory authority." *Kontrick v. Ryan*, 540 U.S. 443, 455 (2004). Section 1395*oo*(a) —which provides for the "Establishment" of the PRRB—defines the Board's power to act by specifying both the parties who are eligible to seek a hearing and the class of cases that the Board may hear. As to the latter, subsection (a) expressly conditions the right to a hearing on the satisfaction of three parallel and identically situated conditions relating to (1) the appropriate subject matter of a provider appeal; (2) the minimum amount in controversy for such an appeal; and (3) the time within which such an appeal must be filed. *See* 42 U.S.C. § 1395*oo*(a)(1)-(3). Because it explicitly provides for the Board's "Establishment" and defines the classes of cases falling within the Board's adjudicative authority, the text of § 1395*oo*(a)—including the timely filing

requirement in subsection (a)(3)—represents a classic jurisdictional provision. *See, e.g., Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 89 (1998). Indeed, if subsection (a) does not define the Board's jurisdiction, then no provision in the statute does. The fact that § 1395*oo*(a)(3) is an integral component of a provision that speaks in jurisdictional terms distinguishes this case from others in which the Court has held a procedural requirement to be nonjurisdictional. *See, e.g., Henderson*, 131 S. Ct. at 1202-03; *Reed Elsevier*, 130 S. Ct. at 1245-46; *Union Pacific R.R. Co. v. Brotherhood of Locomotive Eng'rs & Trainmen Gen. Comm. of Adjustment, Central Region*, 130 S. Ct. 584, 599 (2009); *Arbaugh*, 546 U.S. at 514-15; *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 393-94 (1982).

B. The structure of § 1395*oo* and its relationship to other parts of the Medicare Act confirm that subsection (a)(3)'s timeliness requirement is jurisdictional. In its most recent case to address the status of a timely filing requirement—*Henderson v. Shinseki*, *supra*—this Court found that the procedural informality of the veterans' benefits review statute and the statute's overall solicitude for the procedural rights of veterans precluded attributing to Congress the intention to treat a particular statutory filing deadline as a strict jurisdictional rule. *See Henderson*, 131 S. Ct. at 1205-06. The Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1329, 1420—of which § 1395*oo* was a part—convey the opposite message. Section 1395*oo* itself adopts crisp and unqualified procedural preconditions that ask Medicare providers to turn square corners when seeking to appeal an intermediary's reimbursement decision. The Medicare Act as a whole, moreover, draws an explicit and telling contrast between the

timely filing requirements that apply to sophisticated Medicare *providers* and those that apply to individual Medicare *beneficiaries*. The timely filing requirements for sophisticated Medicare providers who wish to pursue either administrative or judicial review speak in strict and unqualified terms. *See* 42 U.S.C. § 1395*oo*(a)(3), (f)(1). At the same time, the Act prescribes for Medicare beneficiaries virtually the same timely filing *periods* as it does for providers—but then expressly confers upon the Secretary, in addition, administrative discretion to extend those deadlines. *See id.* § 1395ff(b). This disparate inclusion and omission of administrative discretion makes clear that Congress struck a deliberate balance when it enacted § 1395*oo*(a)(3) in sharp and unqualified terms. *See, e.g.*, *Sosa v. Alvarez-Machain*, 542 U.S. 692, 711 n.9 (2004) (using similar structural reasoning); *Russello v. United States*, 464 U.S. 16, 23 (1983) (same).

C. The Secretary's longstanding embrace of a "good cause" exception to § 1395*oo*(a)(3)'s 180-day limit does not negate the conclusion that the timely filing requirement is jurisdictional. It is true that the regulatory "good cause" exception is at odds with the premise that the 180-day limit is jurisdictional. The Secretary, moreover, adopted the "good cause" regulation in a format that makes the resulting interpretation at least *Chevron*-eligible. *See United States v. Mead Corp.*, 533 U.S. 218, 229-30 (2001). Nonetheless, the Secretary's position is not entitled to deference under the circumstances in this case. Because the text and structure of the statute make clear that § 1395*oo*(a)(3)'s timely filing requirement is jurisdictional, Congress has addressed the precise question at issue, requiring both the agency and the

judiciary to "give effect to" its decision. *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). Nor should the Court treat the agency's longstanding position about "good cause" as persuasive indirect evidence of statutory meaning. *See, e.g., Andrus v. Shell Oil Co.*, 446 U.S. 657, 667-68 (1980); *Norwegian Nitrogen Prods. Co. v. United States*, 288 U.S. 294, 314-15 (1933). The position of the responsible agencies on the status of subsection (a)(3) has been, at best, inconsistent. Putting the "good cause" exception to one side, the Secretary, CMS, and the PRRB have repeatedly treated § 1395*oo*(a)'s requirements—including subsection (a)(3)'s timely filing requirement—as "jurisdictional." The Secretary, moreover, has yet to reconcile her "good cause" exception with that position. Accordingly, were this Court to hold that the timely filing requirement is jurisdictional, that ruling would not contradict any clearly articulated or consistently held agency interpretation of subsection (a)(3).

ARGUMENT

THE 180-DAY DEADLINE FOR FILING AN APPEAL WITH THE BOARD IS JURISDICTIONAL AND THUS MAY NOT BE EXTENDED

Congress has the power to distinguish procedural requirements that serve as strict "jurisdictional" limits from those that function as more flexible "claims-processing rules." *See, e.g., Henderson v. Shinseki*, 131 S. Ct. 1197, 1202-03 (2011); *Reed Elsevier, Inc. v. Muchnick*, 130 S. Ct. 1237, 1243-44 (2010). The concept of "jurisdiction," properly understood, describes a tribunal's very authority to decide a case, and a jurisdictional rule is therefore one that defines a tribunal's adjudicative power. *See, e.g., Kontrick v.*

Ryan, 540 U.S. 443, 455 (2004); *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 89 (1998).[8] Because a jurisdictional rule serves a strict power-delimiting function, this Court has traditionally held that such rules are not subject to waiver, forfeiture, or—in the case of jurisdictional time limits—equitable tolling. *See, e.g., Gonzalez v. Thaler*, 132 S. Ct. 641, 648 (2012); *Dolan v. United States*, 130 S. Ct. 2533, 2538 (2010); *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 133-34 (2008); *United States v. Cotton*, 535 U.S. 625, 630 (2002). In contrast, because a claims-processing rule merely "seek[s] to promote the orderly progress of litigation by requiring that the parties take certain procedural steps at certain specified times," *Henderson*, 131 S. Ct. at 1203, such rules are traditionally subject to waiver or estoppel. *See United States v. Locke*, 471 U.S. 84, 94 n.10 (1985). Nonjurisdictional timely filing requirements, moreover, are (at least presumptively) subject to equitable tolling. *See Irwin v. Department of Veterans Affairs*, 498 U.S. 89, 95-96 (1990).

Because a jurisdictional rule and a claims-processing rule may embody identical types of requirements (such as time limitations), this Court has made clear that the difference between the two depends on the intention Congress has expressed

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[8] Though these jurisdictional principles are often articulated in the context of Article III courts, they apply no less to non-Article III tribunals whose powers are established and defined by Congress pursuant to its authority under the Necessary and Proper Clause, U.S. Const. art. I, § 8, cl. 18. *See United States v. Denedo*, 556 U.S. 904, 912 (2009) ("[I]t is for Congress to determine the subject-matter jurisdiction of federal courts. . . . This rule applies with added force to Article I tribunals, . . . which owe their existence to Congress' authority to enact legislation pursuant to Art. I, § 8 of the Constitution.").

about the "nature" of the particular rule. *Henderson*, 131 S. Ct. at 1203. Because the resulting inquiry can be "confusing in practice," *Reed Elsevier*, 130 S. Ct. at 1243, moreover, this Court has developed a "readily administrable bright line" rule for sorting jurisdictional rules from claims-processing rules. *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 516 (2006). Accordingly, as a way both "to capture Congress' likely intent and . . . [to] provide[] helpful guidance for courts and litigants," this Court now "look[s] to see if there is any 'clear' indication that Congress wanted [a procedural] rule to be 'jurisdictional.'" *Henderson*, 131 S. Ct. at 1203. Although framed as a "clear-statement principle," *Gonzalez*, 132 S. Ct. at 648-49, this approach does not require Congress to "use magic words in order to speak clearly." *Henderson*, 131 S. Ct. at 1203. Rather, the Court uses all the traditional tools of statutory construction—including the language, context, structure, and purpose of a statute—to determine whether Congress has clearly indicated that a procedural rule is jurisdictional. *See, e.g., id.* at 1204-06; *Dolan*, 130 S. Ct. at 2538; *Reed Elsevier*, 130 S. Ct. at 1248; *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 393 (1982).[9] As is true of any

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[9] In other words, this Court has not adopted the kind of strong clear-statement rule that it has, at times, used to protect a constitutional norm such as federalism. *See, e.g., Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991) ("[I]f Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'") (quoting *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985)); *Dellmuth v. Muth*, 491 U.S. 223, 228 (1989) (applying the same clear-statement rule to the question whether a federal statute abrogated state sovereign immunity). Whereas those strong clear-statement rules find their justification directly in the protection of a constitutionally derived value, the jurisdictional

question of statutory interpretation, this approach "leave[s] the ball in Congress' court." *Arbaugh*, 546 U.S. at 515-16.

Under this framework, this Court has frequently found timely filing requirements to be claims-processing rules. *See Henderson*, 131 S. Ct. at 1203 (so noting). But it has also recognized that Congress may instead choose to treat such requirements as strictly jurisdictional in order to achieve "a broader system-related goal, such as facilitating the administration of claims, limiting the scope of a governmental waiver of sovereign immunity, or promoting judicial efficiency." *John R. Sand & Gravel*, 552 U.S. at 133 (citations omitted). In particular, when "serious administrative problems" might ensue from applying a flexible limitations period to a massive and complex regulatory scheme, Congress has at times adopted uncompromising time requirements that protect administrative workability at "the price of occasional unfairness in individual cases." *United States v. Brockamp*, 519 U.S. 347, 352-53 (1997) (construing a statute of limitations governing tax refunds). Given the scope and scale of the Medicare reimbursement system,[10] as well as the generally

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rule of thumb at issue in this case is a policy-based canon, rooted in concerns about the systemic costs that a (nonwaivable) jurisdictional rule imposes on courts and litigants by altering the usual operation of the adversary system. *See, e.g., Henderson*, 131 S. Ct. at 1202. Thus, this Court seems to have treated its jurisdiction canon more as a presumption against jurisdictional status than as a rule that requires Congress to express itself with extraordinary clarity on the face of the text.

[10] Even passing familiarity with the Medicare provider reimbursement system confirms that the system is highly complex. *See Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 404 (1993). The Medicare scheme also operates on a massive scale; as

high level of legal sophistication of Medicare providers,[11] Congress could surely have chosen to strike such a balance here. The language and structure of 42 U.S.C. § 1395*oo*(a) and its relationship to the Medicare Act as a whole clearly indicate that Congress did, in fact, do so by casting § 1395*oo*(a) in jurisdictional terms and by omitting from it the same flexibility over timing that the Medicare Act conferred upon the Secretary, in express terms, in other relevant contexts.

A. The Language And Context Of § 1395*oo*(a) Make Clear That The 180-Day Time Limit Is A Crucial Element In The Delineation Of The Board's Jurisdiction To Hear Cases

"'Statutory construction,'" of course, "'must begin with the language employed by Congress.'" *Milner v. Department of the Navy*, 131 S. Ct. 1259, 1264 (2011) (quoting *Park 'N Fly, Inc. v. Dollar Park & Fly, Inc.*, 469 U.S. 189, 194 (1985)). Although § 1395*oo*(a) does not use the "magic word" (jurisdiction), the text of that provision unmistakably defines the jurisdiction of the PRRB. Jurisdictional provisions "delineat[e] the classes of cases (subject-matter jurisdiction) and the persons (personal jurisdiction) falling within a

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of last year, the system processed approximately 250 billion dollars of Part A claims filed by more than 25,000 providers. *See* CMS, 2011 CMS Statistics, Tbls. II.3, III.5 (June 2011), *at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html (last visited Aug. 27, 2012).

[11] *See Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 456 (1999) ("[E]ach of the tens of thousands of sophisticated [Medicare providers] . . . is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3).").

court's adjudicatory authority." *Kontrick*, 540 U.S. at 455. *Accord, e.g.*, *Reed Elsevier*, 130 S. Ct. at 1243; *Eberhart v. United States*, 546 U.S. 12, 16 (2005) (per curiam). A timely filing requirement, therefore, qualifies as "'jurisdictional' when Congress prohibits federal courts from adjudicating an otherwise legitimate 'class of cases' after a certain period has elapsed" from a specified event. *Bowles v. Russell*, 551 U.S. 205, 213 (2007).

By this measure, § 1395*oo*(a)—including the timely filing requirement at issue here—is a classic jurisdictional provision. Section 1395*oo* is entitled "Provider Reimbursement Review Board," and subsection (a) specifically addresses, as its caption states, the Board's "Establishment." 42 U.S.C. § 1395*oo*(a); *see, e.g.*, *Florida Dep't of Revenue v. Piccadilly Cafeterias, Inc.*, 554 U.S. 33, 47 (2008) (title or caption may provide context for understanding the text); *Porter v. Nussle*, 534 U.S. 516, 527-28 (2002) (same). Consistent with that descriptor, subsection (a) establishes the Board's authority by carefully defining what cases it may hear. Subsection (a) begins by defining the *class of parties* eligible for a hearing before the Board. *See* 42 U.S.C. § 1395*oo*(a) (authorizing hearings for providers that "ha[ve] filed a required cost report [with an intermediary] within the time specified in regulations" or "submitted such reports within such time as the Secretary may require" for purposes of the prospective payment system). The statute then delineates the appropriate *class of cases* the Board may hear, dictating that providers "may obtain a hearing . . . *if*" the provider satisfies the three numbered requirements. *Id.* (emphasis added).

The first such requirement—codified in subsection (a)(1)—specifies the subject matter of the claims that

otherwise eligible providers may bring to the Board. Specifically, a provider may obtain review in three carefully defined circumstances. First, review is available if the provider is "dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report." *Id.* § 1395*oo*(a)(1)(A)(i). Second, a provider may invoke the Board's authority if "dissatisfied with a final determination of the Secretary as to the amount of the payment under" the prospective payment system (prescribed by 42 U.S.C. § 1395ww(b), (d)). *Id.* § 1395*oo*(a)(1)(A)(ii). Finally, the provider may seek redress before the Board if the provider "has not received [a] final determination [NPR] from [an] intermediary on a timely basis after filing [a cost] report, where such report complied with the rules and regulations of the Secretary relating to such report." *Id.* § 1395*oo*(a)(1)(B); *see also id.* § 1395*oo*(a)(1)(C) (authorizing review of untimely responses to a "supplementary cost report"). These provisions serve precisely the same function as numerous provisions of the Judicial Code that define subject-matter jurisdiction by reference to the type of claim that may be asserted. *See Arbaugh*, 546 U.S. at 515 n.11 (giving examples); *see also, e.g.*, 28 U.S.C. § 1339 ("any civil action arising under any Act of Congress relating to the postal service"); *id.* § 1347 ("any civil action commenced by any tenant in common or joint tenant for the partition of lands where the United States is one of the tenants in common or joint tenants"). To the extent that they have considered the question, moreover, the federal courts and the responsible

agencies have consistently described subsection (a)(1) as a jurisdictional element.[12]

The second condition for obtaining a hearing—codified in the parallel subsection (a)(2)—also reflects a familiar jurisdictional requirement: A provider may obtain a hearing only "if ... the amount in controversy is $10,000 or more." 42 U.S.C. § 1395*oo*(a)(2). Perhaps in part because of its salient role in defining diversity jurisdiction and, until 1980, federal-question jurisdiction, the amount-in-controversy requirement is commonly thought of as a "threshold ingredient" of a tribunal's jurisdiction. *Arbaugh*, 546 U.S. at 515; *see* 28 U.S.C. § 1331 (1976) (former federal-question statute); 28 U.S.C. § 1332(a) (diversity jurisdiction); *see also, e.g.*, 16 U.S.C. § 814; 22 U.S.C. § 6713(a)(1)(B); 28 U.S.C. § 1346(a)(2).

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[12] This Court, for example, has written that "a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction." *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 404 (1988). The relevant agencies have also treated the provision as jurisdictional. *See, e.g.*, *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, No. 2006-D20, 2006 WL 1684639, at *35 n.107 (CMS Adm'r May 11, 2006) (observing that, with respect to subsection (a)(1)'s "dissatisfaction" requirement, "[j]urisdiction can never be waived"); *Select Specialty Hosp. v. Mutual of Omaha Ins. Co.*, No. 2005-D38, 2005 WL 3741460, at *3-4 (CMS Adm'r July 11, 2005) (noting that, "[b]y failing to present a claim for reimbursement," the provider "failed to meet the threshold test for Board jurisdiction"). Thus, for example, where the provider is not "dissatisfied" with the amount of reimbursement but merely asks the Board to determine which competing claimant is entitled to receive the reimbursement, the Board has disclaimed jurisdiction to hear the case. *See, e.g.*, *Home Care PRN v. Blue Cross & Blue Shield Ass'n*, No. 2004-D1, 2003 WL 22490094, at *2 (PRRB Oct. 14, 2004); *Florida Convalescent Ctrs. 97 Therapy Mgmt. Fee Group v. BlueCross BlueShield Ass'n*, No. 2004-D45, 2004 WL 2584861, at *3 (PRRB Sept. 30, 2004).

Again, the federal courts and the relevant agencies have described subsection (a)(2) as an element of the Board's jurisdiction.[13]

Finally, the third condition—and the one at issue here—prescribes a timely filing requirement. In particular, a provider may obtain a hearing

> if . . . such provider files a request for a hearing within 180 days after notice of the intermediary's

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[13] Though this Court has never had occasion to speak to the question, lower federal courts have routinely characterized subsection (a)(2) as a jurisdictional requirement. *See, e.g., Beacon Healthcare Servs., Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010) (holding that the amount-in-controversy provision goes to the Board's jurisdiction, and not to whether the plaintiffs in fact stated a claim on which the requested relief could be granted); *St. Francis Med. Ctr. v. Sullivan*, 962 F.2d 1110, 1114-15 (3d Cir. 1992) (holding that the Board did not have jurisdiction over a provider application that did not meet the amount-in-controversy requirement); *Georgetown Univ. Hosp. v. Sullivan*, 934 F.2d 1280, 1284-85 & nn.6-7 (D.C. Cir. 1991) (describing subsection (a)(2)'s amount-in-controversy provision as a "jurisdictional requirement").

In its cases, moreover, the PRRB has similarly conceived of subsection (a)(2) as a jurisdictional requirement. *See, e.g., Interim Health Care v. BlueCross BlueShield Ass'n*, No. 2010-D49, 2010 WL 4211383, at *4 (PRRB Sept. 24, 2010) (analogizing subsection (a)(2)'s amount-in-controversy requirement to that of 28 U.S.C. § 1332 and using criteria developed under § 1332 to calculate the amount in controversy); *Salt Lake Reg'l Med. Ctr. v. BlueCross BlueShield Ass'n*, No. 2010-D39, 2010 WL 4214208, at *9 (PRRB June 30, 2010) (explaining that "the amount in controversy is a fundamental requirement for Board jurisdiction"). Consistent with this position, current HHS regulations provide that, "[w]hen . . . the amount in controversy changes to an amount less than the minimum for a Board appeal due to . . . [a] more accurate assessment of the amount in controversy, the Board does not retain jurisdiction." 42 C.F.R. § 405.1839(c)(5)(B) (2011).

> final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. § 1395*oo*(a)(3). This timely filing requirement directly parallels the subject-matter and amount-in-controversy requirements, and all three follow conjunctively after the phrase indicating that an otherwise eligible provider may obtain review only "if" all three requirements are met. Given their identical placement in the statute as conditions upon the invocation of the Board's hearing authority, there is simply no basis for treating some of these requirements as jurisdictional and others as nonjurisdictional. All three operate in an integrated way to define and delimit the Board's authority to hear provider appeals.

Because the three identically situated subsections operate in conjunction to define and condition the Board's exercise of authority, the Board or a reviewing court can no more alter the timeliness requirement than it could alter the subject-matter or amount-in-controversy requirements. If the Board adopted a regulation stating that it would hear appeals "having an amount in controversy of $5,000 for good cause if the matter involves a recurring issue central to the administration of Medicare Part A," that regulation would undoubtedly exceed the Board's authority. It would bring within the Board's jurisdiction cases that Congress specified it could not hear. *See Lyng v. Payne*, 476 U.S. 926, 937 (1986)

("[A]n agency's power is no greater than that delegated to it by Congress."). An agency regulation extending the time for filing beyond the 180 days specified by the statute—or a judicial decree equitably tolling that statutory limit on the agency's power—has the same effect.

The fact that the timely filing requirement is an element of a statutory provision that speaks in jurisdictional terms and establishes the Board's powers distinguishes this case from other recent cases holding a procedural requirement to be nonjurisdictional. In *Arbaugh*, for example, this Court held that Title VII's self-limitation to employers with at least 15 employees, 42 U.S.C. § 2000e(b), was nonjurisdictional, reasoning that the numerosity requirement did not appear in "Title VII's jurisdictional provision, 42 U.S.C. § 2000e-5(f)(3)," but rather "in a separate provision that 'does not speak in jurisdictional terms or refer in any way to the jurisdiction of the district courts.'" 546 U.S. at 515 (quoting *Zipes*, 455 U.S. at 394); *see also Zipes*, 455 U.S. at 393-94 (similarly noting that the Title VII provision "specifying the time for filing charges with the [Equal Employment Opportunity Commission]" is "entirely separate" from Title VII's jurisdictional provisions). Similarly, in *Reed Elsevier, Inc. v. Muchnick*, *supra*, the Court held that the Copyright Act's registration requirement, 17 U.S.C. § 411—though framed as a prerequisite to filing a civil action—was not jurisdictional, in part, because that "requirement . . . is located in a provision 'separate' from those granting federal courts subject-matter jurisdiction over those . . . claims." 130 S. Ct. at 1245-46. And in *Union Pacific Railroad Co. v. Brotherhood of Locomotive Engineers & Trainmen General Committee of Adjustment, Central*

Region, 130 S. Ct. 584 (2009), this Court found that a pre-arbitration settlement conference required by the Railway Labor Act, 45 U.S.C. § 151 *et seq.* ("RLA"), was nonjurisdictional, in part, because "the conference requirement is stated in the '[g]eneral duties' section of the RLA, § 152, a section that is not moored to the '[e]stablishment[,] . . . powers[,] and duties' of the [arbitration board] set out next in § 153 First." 130 S. Ct. at 597 (alterations and ellipsis in original); *see also* p. 30, *infra* (discussing similar reasoning in *Henderson*).[14] In contrast, because § 1395*oo*(a) speaks in jurisdictional terms by defining

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[14] Other recent cases rest on a similar distinction. For example, in *Kontrick v. Ryan*, *supra*, this Court declined to treat a timely objection requirement in bankruptcy proceedings as jurisdictional, despite the requirement's emphatic wording. In reaching that conclusion, the Court reasoned that the requirement in question did not originate in any of the statutes defining the bankruptcy court's subject-matter jurisdiction, but rather appeared in a Federal Rule of Bankruptcy Procedure promulgated by this Court pursuant to its authority to prescribe "the practice and procedure in cases under title 11," 28 U.S.C. § 2075. *See* 540 U.S. at 453-54. In *Eberhart v. United States*, *supra*, this Court relied on *Kontrick*'s reasoning to hold that a "closely parallel" set of requirements governing new trial motions under the Federal Rules of Criminal Procedure was also nonjurisdictional. *See* 546 U.S. at 15-16; *see also Owen Equip. & Erection Co. v. Kroger*, 437 U.S. 365, 370 (1978) (deeming it "axiomatic" that Court-prescribed rules of practice and procedure "do not create or withdraw federal jurisdiction"). And in *Scarborough v. Principi*, 541 U.S. 401 (2004), this Court held that the statutory deadline for filing an attorney's fee application under the Equal Access to Justice Act, 28 U.S.C. § 2412(d)(1)(B), was nonjurisdictional because it involved a form of relief ancillary to the judgment of a court that already had jurisdiction over the case. *See* 541 U.S. at 413. In contrast with all of those cases, the timely filing requirement at issue in this case appears in the very provision that defines the Board's jurisdiction.

the Board's power to act, this Court should construe its component requirements—including the 180-day timely filing requirement—as jurisdictional.[15]

This Court's decision in *Gonzalez v. Thaler*, *supra*, does not require a different result. At issue in *Gonzalez* was the status of a procedural requirement for appealing a district court's final order in a habeas proceeding—namely, the requirement that the "certi-

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[15] It is true that § 1395*oo*(a) is phrased in terms of the provider's right to seek review rather than the Board's power to hear an appeal. But that factor does not negate the conclusion that § 1395*oo*(a) speaks in jurisdictional terms. In fact, because the right to invoke a tribunal's power is the mirror image of the tribunal's power to hear the case, jurisdictional statutes often speak in terms of a litigant's conditional right to invoke the tribunal's authority. *See, e.g.*, 16 U.S.C. § 814 (establishing the conditions pursuant to which a licensee of the Federal Energy Regulatory Commission may acquire certain property rights "by the exercise of the right of eminent domain in the district court of the United States for the district in which such land or other property may be located, or in the State courts"); 28 U.S.C. § 2101(c) ("Any other appeal or any writ of certiorari intended to bring any judgment or decree in a civil action, suit or proceeding before the Supreme Court for review shall be taken or applied for within ninety days after the entry of such judgment or decree."); *id.* § 2107(a) ("[N]o appeal shall bring any judgment, order or decree in an action, suit or proceeding of a civil nature before a court of appeals for review unless notice of appeal is filed, within thirty days after the entry of such judgment, order or decree."); *id.* § 2253(c)(1) ("Unless a circuit justice or judge issues a certificate of appealability, an appeal may not be taken to the court of appeals from . . . the final order in a habeas corpus proceeding in which the detention complained of arises out of process issued by a State court . . . ."); *see also, e.g.*, *Bowles*, 551 U.S. at 213 (reaffirming that § 2107 is jurisdictional); *Miller-El v. Cockrell*, 537 U.S. 322, 336 (2003) (reading § 2253(c)(1) as jurisdictional); *FEC v. NRA Political Victory Fund*, 513 U.S. 88, 90 (1994) (holding that § 2101(c) is jurisdictional).

ficate of appealability" needed for such an appeal must indicate the "specific issue or issues" on which the petitioner made a substantial "showing" of constitutional deprivation. 28 U.S.C. § 2253(c)(3); *see also id.* § 2253(c)(2). While acknowledging that § 2253(c)(1)—the related provision conditioning the right to appeal on issuance of a certificate of appealability—*was* jurisdictional, this Court found that § 2253(c)(3)'s specification of the content of such a certificate was not. *Gonzalez*, 132 S. Ct. at 649-50. In so holding, this Court rejected the government's argument that "the placement of § 2253(c)(3) in a section containing jurisdictional provisions signals that it too is jurisdictional." *Id.* at 651. Rather, as the Court noted, "[m]ere proximity will not turn a rule that speaks in nonjurisdictional terms into a jurisdictional hurdle." *Id.* Indeed, subsection (c)(3)'s "proximity to" provisions that spoke in terms of the court of appeals' power to act merely served to "highlight[] the absence of clear jurisdictional terms in § 2253(c)(3)." *Id.*[16]

In contrast with the provision at issue in *Gonzalez*, § 1395*oo*(a)(3)'s 180-day filing requirement is not jurisdictional merely because it is *proximate* to other

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[16] The Court in *Gonzalez* gave particular emphasis to the disparate framing of subsections (c)(1) and (c)(3). *See* 132 S. Ct. at 649. Subsection (c)(1) provides that, "[u]nless a circuit justice or judge issues a certificate of appealability, an appeal may not be taken to the court of appeals." 28 U.S.C. § 2253(c)(1). In contrast, subsection (c)(3) states merely that "[t]he certificate of appealability under paragraph (1) shall indicate which specific issue or issues satisfy the [substantial showing of constitutional deprivation] required by paragraph (2)." *Id.* § 2253(c)(3). Unlike subsection (c)(1), therefore, subsection (c)(3) is not explicitly phrased in terms that delineate the power of the court of appeals to act.

plainly jurisdictional provisions. Rather, it is part and parcel of a set of three integrated provisions that together *define* the Board's very authority to grant a provider a hearing. On its face, subsection (a) as a whole provides for the Board's "Establishment" and expressly "delineat[es] the classes of cases . . . and the persons . . . falling within [the tribunal's] adjudicatory authority." *Kontrick*, 540 U.S. at 455. Indeed, if § 1395*oo*(a) does not define the Board's jurisdiction, then no provision of the statute does. And, in contrast with the habeas statute at issue in *Gonzalez*, nothing about the placement or wording of § 1395*oo*(a)'s three numbered subsections provides any basis for distinguishing among them in the performance of that classic jurisdictional function.

Nor does the fact that subsection (a)(3) involves a timely filing requirement negate the jurisdictional function that it serves in subsection (a). To be sure, this Court in *Henderson v. Shinseki*, *supra*, recently described timely filing requirements as "quintessential claim-processing rules." 131 S. Ct. at 1203. But it also made clear that, even where a timely filing requirement is concerned, Congress is "free to attach the conditions that go with the jurisdictional label to a rule that we would prefer to call a claim-processing rule." *Id.* That is, even if such time limits are typically claims-processing rules, Congress may at times choose to treat them as jurisdictional in order to achieve "a broader system-related goal, such as facilitating the administration of claims, limiting the scope of a governmental waiver of sovereign immunity, or promoting judicial efficiency." *John R. Sand & Gravel*, 552 U.S. at 133 (citations omitted); *see also Bowles*, 551 U.S. at 213 ("[T]he notion of subject-matter jurisdiction obviously extends to classes of

cases . . . falling within a court's adjudicatory authority, but it is no less jurisdictional when Congress prohibits federal courts from adjudicating an otherwise legitimate class of cases after a certain period has elapsed from final judgment.") (citations and internal quotation marks omitted; ellipsis in original). Accordingly, as it does with any procedural requirement, this Court must consult all the applicable tools of statutory construction to determine whether Congress clearly intended or understood a particular timely filing requirement to be jurisdictional. *See Henderson*, 131 S. Ct. at 1203, 1204-06.

It is true that, in recent years, this Court has tended to find timely filing requirements jurisdictional largely in those contexts in which well-settled precedents had long treated a particular category of timeliness provisions as such. *See, e.g., John R. Sand & Gravel*, 552 U.S. at 134-36 (periods for filing claims against the United States in various iterations of courts of claims); *Bowles*, 551 U.S. at 209-10 (time limits for filing notices of appeal). But *Henderson* itself makes plain that time limits may be jurisdictional even when they do not fall into such a category and that all the traditional tools of statutory interpretation still apply. The Court in *Henderson* held that the time limit there at issue—the filing period for a notice of appeal from one non-Article III adjudicative body (the Board of Veterans' Appeals) to another (the U.S. Court of Appeals for Veterans Claims)—did not fall within any category whose jurisdictional status had been established by long-standing precedent. *See* 131 S. Ct. at 1203 (distinguishing *Bowles* on the ground that it dealt with court-to-court notices of appeal). Yet the Court found it necessary to go on to scrutinize with care the text,

context, and structure of the legislation governing veterans' claims in order to determine whether Congress meant that *particular* time limit to be jurisdictional. *See id.* at 1204-06.

Accordingly, this Court found the timely filing requirement in *Henderson* to be nonjurisdictional only after assuring itself that the text of that requirement did not speak in jurisdictional terms or in any way indicate that Congress "wanted [it] to be treated as having jurisdictional attributes." *Id.* at 1205. In addition, taking a page from other recent cases (*see* pp. 24-26 & n.14, *supra*), the Court found it significant that the timely filing requirement appeared "in a subchapter [of the Veterans' Judicial Review Act, Pub. L. No. 100-687, Div. A, 102 Stat. 4105 (1988),] entitled 'Procedure,'" and not in the "subchapter entitled 'Organization and Jurisdiction.'" *Id.* at 1205. Finally, with respect to the statute's overall structure, the Court emphasized that the "most telling" evidence of legislative intent derived from "the singular characteristics of the review scheme that Congress created for the adjudication of veterans' benefits claims." *Id.* Because the scheme as a whole reflected procedural informality, flexibility, and solicitude for veterans, *see id.* at 1205-06, treating the time limit at issue as jurisdictional "would clash sharply with [the overall] scheme," *id.* at 1206.[17]

Applying *Henderson*'s analytical framework to the time limits for Medicare provider appeals yields the opposite result. As discussed above, in sharp con-

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[17] The Court also relied on the well-settled "'canon that provisions for benefits to members of the Armed Services are to be construed in the beneficiaries' favor.'" *Henderson*, 131 S. Ct. at 1206 (quoting *King v. St. Vincent's Hosp.*, 502 U.S. 215, 220-21 n.9 (1991)). No similar canon governs here.

trast with the scheme at issue in *Henderson*, the text of § 1395*oo*(a)(3) makes clear that the time requirement is an integral component of the very provision that delineates the PRRB's jurisdiction—its authority to hear cases. *See* pp. 19-24, *supra*. Even more tellingly, as elaborated below, *see* Part B, *infra*, the strict tenor of § 1395*oo* as a whole—and the contrast between its strict timeliness provisions and the more flexible ones found elsewhere in the Medicare Act—make plain that Congress intended the 180-day filing requirement to function as a strict jurisdictional rule, and not as a flexible claims-processing rule.

B. The Structure Of § 1395*oo*(a) And That Of The Medicare Act As A Whole Clearly Indicate That Congress Intended Subsection (a)(3)'s 180-Day Time Limit To Be Strictly Jurisdictional

This Court has explained that, "'[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.'" *United States Nat'l Bank of Oregon v. Independent Ins. Agents of Am., Inc.*, 508 U.S. 439, 455 (1993) (quoting *United States v. Heirs of Boisdore*, 49 U.S. (8 How.) 113, 122 (1849)). Indeed, as the Court has noted, reading a particular procedural requirement in the context of the overall statutory scheme may provide the "most telling" evidence of whether Congress intended that requirement to be jurisdictional. *Henderson*, 131 S. Ct. at 1205. The Medicare Act's structure makes clear that Congress in fact meant to draw the strict and unyielding limitation that § 1395*oo*(a)(3)'s unqualified terms suggest.

Reading the timely filing requirements of § 1395*oo*(a)(3) as jurisdictional harmonizes it with the overall approach of a review scheme that sharply and carefully delineates Medicare providers' rights to challenge their reimbursements. *See* pp. 3-4, 19-24, *supra* (discussing the provider benefits review scheme in greater detail). For example, a provider may obtain a hearing before the PRRB only if it has first filed required cost, or other, reports with the intermediary or the Secretary in a timely fashion. *See* 42 U.S.C. § 1395*oo*(a).[18] In addition, the statute specifies in precise detail which claims providers may bring to the Board—and which claims fall outside its powers. Subsection (a)(1), as noted, requires that a provider must be "dissatisfied with a final determination" either "of . . . its fiscal intermediary . . . as to the amount of total program reimbursement" or "of the Secretary as to the amount of the payment" the provider is to receive under the prospective payment system. *Id.* § 1395*oo*(a)(1)(A)(i), (ii). Aside from that class of cases, a provider may appeal only the intermediary's failure to file an NPR "on a timely basis"—and then only if the cost report or supplemental cost report filed with the intermediary "complied with the rules and regulations of the Secretary relating to such report." *Id.* § 1395*oo*(a)(1)(B), (C). The statute also restricts group appeals to cases in which "the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more." *Id.* § 1395*oo*(b).

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[18] For further discussion of the underlying deadline, see note 21, *infra*.

Even within the class of otherwise allowable claims, moreover, the statute expressly excludes from review certain findings—such as the intermediary's denial of reimbursement, under 42 U.S.C. § 1395y, for various procedures or tests that are "not reasonable and necessary" or are "performed more frequently" than is covered by the statute, *id.* § 1395y(a)(1). *See id.* § 1395oo(g)(1). Finally, the provision authorizing expedited judicial review makes clear that neither the Board nor CMS has authority to entertain a provider's challenges to the validity of the governing regulations; a provider must submit its claims for reimbursement on the assumption that the regulations are valid and contest their validity, if at all, only upon judicial review. *See id.* § 1395oo(f)(1); *see also Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 406 & n.4 (1988) (drawing that inference from § 1395oo(f)(1)).[19] The apparent strictness of the timely filing requirements thus fits neatly with, rather than contradicts, the overall tenor of a statute

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[19] The Secretary has by regulation denied the Board authority to invalidate regulations issued pursuant to the Medicare Act or CMS Rulings interpreting the statute and regulations. *See* 42 C.F.R. § 405.1867 (2011). Accordingly, to avoid needless Board proceedings where a provider's challenge to an intermediary's decision turns on the validity of a regulation or a CMS Ruling, *see* H.R. Rep. No. 96-1167, at 394 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5526, 5757, the statute gives providers "the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines . . . that it is without authority to decide the question." 42 U.S.C. § 1395oo(f)(1). A provider may seek such a determination of eligibility, however, only if that provider could otherwise "obtain a hearing under subsection (a) of this section and has filed a request for such a hearing." *Id.*

that generally asks providers to turn square corners in pursuing their appellate rights.[20]

More importantly, the Medicare Act's disparate treatment of timely filing requirements for Medicare *providers*, on the one hand, and for individual Medicare *beneficiaries*, on the other, makes clear that the timeliness requirements applicable to the former are jurisdictional. Where providers are concerned, the Act adopts a set of strict timely filing requirements that are consistent with the assumption that "each of the tens of thousands of sophisticated [Medicare providers] . . . is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Your Home Visiting Nurse Servs.*, 525 U.S. at 456. For individual Medicare beneficiaries, however, the Act borrowed explicitly flexible timeliness requirements from Social Security procedures "that Congress designed to be 'unusually protective' of [individual] claimants." *Bowen v. City of New York*, 476 U.S 467, 480 (1986) (quoting *Heckler v. Day*, 467 U.S. 104 106-07 (1984)).

On their face, the time requirements prescribed for Medicare *provider* appeals under § 1395*oo* are framed in unqualified terms.[21] The particular limit

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[20] Indeed, in those rare instances in which § 1395*oo* contemplates some procedural flexibility, Congress has made its intentions explicit. *See, e.g.*, 42 U.S.C. § 1395*oo*(c) ("Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure."); *see also* note 21, *infra*.

[21] One time requirement in § 1395*oo* contemplates some administrative discretion, but it does not go to the time for taking an appeal. To have standing to appeal an NPR to the Board, a provider must have "filed a required cost report [with

at issue here straightforwardly insists that the provider seek Board review "within 180 days after notice of the intermediary's final determination[,] . . . the Secretary's final determination, or . . . such determination [as] would have been received if such determination had been made on a timely basis." 42 U.S.C. § 1395*oo*(a)(3).[22] The statute then specifies that, after the Board decides, its decision becomes final unless the Secretary (or her delegate) decides *sua sponte* to "reverse[], affirm[], or modif[y]" that decision "within 60 days after the provider of services is notified of the Board's decision." *Id.* § 1395*oo*(f)(1). "[W]ithin 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received," a provider has the right to obtain judicial

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the intermediary] within the time specified in regulations." 42 U.S.C. § 1395*oo*(a). That provision simply makes compliance with the process prescribed elsewhere for obtaining an NPR a condition of appealing that NPR to the Board. The administrative discretion in subsection (a)'s standing provision, moreover, offers a marked contrast to the stricter articulation of the appellate time limits in subsection (a)(3).

[22] In addition, at least one other key provision is expressly synched into the 180-day time limit. When a provider seeks judicial review of the Board's or the Secretary's decisions, the statute provides for prejudgment interest accruing from "the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section." 42 U.S.C. § 1395*oo*(f)(2). That provision has the obvious purpose of timing prejudgment interest from the conclusion of the period for seeking Board review. Significantly, the statute defines that period in the unqualified numerical terms of subsection (a)(3) rather than qualitatively from, for example, "the close of the period for obtaining a hearing with the Board" (as one might expect if some flexibility were contemplated).

review of the Board's or, where relevant, the Secretary's decision. *Id.*[23]

In conspicuous contrast, the Medicare Act prescribes self-evidently flexible time limits for *beneficiaries.*[24] In the 1972 amendments to the Social Security Act—the very statute that adopted the PRRB review scheme at issue here—Congress gave the Secretary explicit discretion over the time requirements for individual Medicare claimants at the levels of both administrative and judicial review. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 299O, 86 Stat. 1329, 1464-65. Rather than adopt novel review procedures, the 1972 amendments applied to individual Medicare claimants those procedures already in effect for Social Security claimants.[25] For administrative appeals—the proce-

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[23] The time limits for expedited review are similarly strict. Once the Board has received materials from the provider seeking expedited judicial review, it must rule "within thirty days," and the provider may "within sixty days of the end of such period" bring a civil action if the Board has failed to rule on its eligibility for expedited judicial review. 42 U.S.C. § 1395*oo*(f)(1).

[24] None of this analysis is meant to suggest that the review provisions for individual beneficiaries are utterly lacking in strictness or precise definition. For example, much like the provider review statute, the beneficiary review statute includes amount-in-controversy requirements for at least some appeals. *See* 42 U.S.C. § 1395ff(b)(1)(E). The analysis here, however, focuses on the statutes' contrasting approaches to building administrative flexibility into the timely filing requirements.

[25] The 1965 legislation that first established Medicare similarly incorporated the Social Security review procedures. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869, 79 Stat. 286, 330. Congress then did so again in the 1972 amendments that also adopted the PRRB scheme.

dure most analogous to the PRRB process—the 1972 amendments incorporated by reference a Social Security provision stating that an administrative appeal "must be filed within such period after [a benefits] decision *as may be prescribed in regulations of the Secretary*, except that the period so prescribed may not be less than six months after notice of such decision is mailed to the individual making such request," 42 U.S.C. § 405(b) (1970) (emphasis added). *See id.* § 1395ff(b) (Supp. II 1973) (incorporating § 405(b) by reference). In effect, this provision sets a minimum filing period of six months but gives the Secretary explicit discretion both to set a deadline and to provide for extensions of that deadline, by regulation. The same Congress, of course, prescribed virtually the identical period of 180 days for a provider's appeal to the PRRB, but conferred *no* administrative discretion to extend.

The provisions authorizing judicial review of the administrative bodies confirm Congress's disparate approach to timely filing requirements in the two contexts. For individual beneficiaries, the 1972 amendments (42 U.S.C. § 1395ff(b) (Supp. II 1973)) incorporated by reference the Social Security procedures codified at 42 U.S.C. § 405(g) (1970), which authorized the claimant to file "a civil action . . . within sixty days after the mailing to him of notice of [the Secretary's] decision *or within such further time as the Secretary may allow*." *Id.* (emphasis added). This Court has read the italicized language as confirmation of Congress's intent not to treat § 405(g) as jurisdictional, but to permit equitable tolling of the

60-day period. *See Bowen*, 476 U.S. at 478 & n.10.[26] Again, the flexibility built into the 60-day filing period for individual beneficiaries is notably missing from the simultaneously enacted 60-day filing period prescribed for judicial review by Medicare providers under § 1395*oo*(f)(1).

The current version of § 1395ff perpetuates the contrast.[27] To simplify somewhat, once a Medicare claimant has received the requisite determination of his or her benefits from an "intermediary or carrier," 42 U.S.C. § 1395ff(a)(3)(B)(i), the claimant may then obtain review by the Secretary if the claimant "files

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[26] Emphasizing that the time limit appears "in a statute that Congress designed to be 'unusually protective' of [individual] claimants," this Court reasoned that authorizing the Secretary to extend the time for filing "express[ed] [a] clear [legislative] intention to allow tolling in some cases." *Bowen*, 476 U.S. at 480 (quoting *Heckler*, 467 U.S. at 106-07). From this starting point, the Court had no difficulty holding that other forms of equitable tolling by the judiciary were consistent with legislative intent. *Id.* The Court had previously concluded, without extended reasoning, that § 405(g)'s filing period is a statute of limitations rather than a jurisdictional limit. *See Mathews v. Eldridge*, 424 U.S. 319, 328 n.9 (1976); *Weinberger v. Salfi*, 422 U.S. 749, 763-64 (1975).

[27] Congress adopted the current version of § 1395ff(b) in the Consolidated Appropriations Act, 2001, Pub. L. No. 106-554, § 521(a), 114 Stat. 2763, 2763A-534 to 2763A-543. Although enacted at a different time, the current version of § 1395ff is also relevant to understanding § 1395*oo*. Where a statutory text permits, the Court will "construe it to contain that permissible meaning which fits most logically and comfortably into the body of both previously and subsequently enacted law." *West Virginia Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 100 (1991). The Court does so "not because that precise accommodative meaning is what the lawmakers must have had in mind . . . , but because it is [the judiciary's] role to make sense rather than nonsense out of the *corpus juris*." *Id.* at 100-01.

notice with the Secretary to request reconsideration by . . . the end of the 180-day period beginning on the date the individual receives notice of the [intermediary's or carrier's ultimate determination] . . . or *within such additional time as the Secretary may allow*." *Id.* § 1395ff(b)(1)(D)(i) (emphasis added). If the claimant also seeks a hearing from the Secretary, the claimant must request such a hearing within "time limits" that the Secretary "shall establish in regulations." *Id.* § 1395ff(b)(1)(D)(ii). After the administrative appeal, unless the claimant wishes to run the gauntlet of relatively strict rules governing expedited judicial review, the statute continues to incorporate the judicial review procedures used for Social Security claimants under 42 U.S.C. § 405(g). *See id.* § 1395ff(b)(1)(A). Section 405(g), in turn, continues to condition judicial review on a claimant's filing for a civil action "within sixty days after . . . notice of such decision or *within such further time as the [Secretary] may allow*." *Id.* § 405(g) (emphasis added).[28]

The contrasting strictness of § 1395*oo*(a)(3) confirms the jurisdictional character of that provision.[29]

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[28] Because § 405(g) addresses judicial review for determinations by the Commissioner of Social Security, the Medicare Act's judicial review provision substitutes "Secretary" for "Commissioner of Social Security" wherever the latter appears in § 405(g). 42 U.S.C. § 1395ff(b)(1)(A).

[29] To be sure, "[n]ot all mandatory 'prescriptions, however emphatic, are . . . properly typed jurisdictional.'" *Union Pacific*, 130 S. Ct. at 596 (quoting *Arbaugh*, 546 U.S. at 510) (ellipsis in original). But the strict character of the time limits for provider appeals and Congress's contrasting treatment of appeals by individual beneficiaries confirm what the text of § 1395*oo*(a) itself establishes—namely, that Congress meant subsection

This Court has often applied the familiar rule that, "'when the legislature uses certain language in one part of the statute and different language in another, the court assumes different meanings were intended.'" *Sosa v. Alvarez-Machain*, 542 U.S. 692, 711 n.9 (2004) (quoting 2A NORMAN J. SINGER, STATUTES AND STATUTORY CONSTRUCTION § 46:06, at 194 (6th ed. 2000)). In particular, "[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983) (internal quotation marks omitted). The provisions of § 1395ff show that, when Congress wished to confer administrative discretion over timeliness requirements, it knew how to do so. *See, e.g., City of Chicago v. Environmental Def. Fund*, 511 U.S. 328, 337-38 (1994) (using similar structural reasoning); *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 176-77 (1994) (same).

In the end, interpreting § 1395*oo*(a)(3) to be non-jurisdictional would read into the statute a kind of discretion over timely filing that Congress conferred expressly in provisions governing Medicare beneficiaries but did not in those governing Medicare providers. This Court should not construe two provisions worded so differently to mean the same thing. "The statute was evidently drawn with care. Its language is plain and unambiguous. . . . To supply omissions transcends the judicial function." *Iselin v. United States*, 270 U.S. 245, 250-51 (1926).

(a)(3)'s timely filing requirement to operate as a jurisdictional provision.

C. The Secretary's "Good Cause" Exception To The 180-Day Filing Requirement Does Not Undermine The Conclusion That § 1395*oo*(a)(3) Is Jurisdictional

Because respondents' claims fall outside the three-year window within which they could have invoked the regulatory "good cause" exception to the 180-day time limit, *see* Pet. App. 55a; 42 C.F.R. § 405.1841(b), the validity of that regulation is not before this Court. Nonetheless, it is necessary to speak briefly to the question whether the agency's "good cause" exception undermines the conclusion that the statutory timely filing requirement is jurisdictional. In particular, because jurisdictional timely filing requirements admit of no equitable exceptions, if the agency's position on the "good cause" exception were entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), that determination would undercut any further conclusion that subsection (a)(3) is jurisdictional. *See Western Med. Enters., Inc. v. Heckler*, 783 F.2d 1376, 1379-80 (9th Cir. 1986). Yet, while the regulations containing the "good cause" exception are eligible for consideration under the *Chevron* framework,[30] the position on jurisdiction implicit in those regulations

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[30] *See Your Home Visiting Nurse Servs.*, 525 U.S. at 453-54. The Secretary has statutory authority to promulgate regulations to carry the Medicare Act into effect. *See, e.g.*, 42 U.S.C. §§ 1302(a), 1395*l*(a), 1395hh(a)(1). The Secretary employed notice-and-comment rulemaking procedures to adopt the version of the "good cause" exception that governs this case, as well as the somewhat stricter version now in effect. *See* 39 Fed. Reg. 34,515 (Sept. 26, 1974); 73 Fed. Reg. 30,190 (May 23, 2008); *see also* note 6, *supra*. Accordingly, both sets of regulations are *Chevron*-eligible under *United States v. Mead Corp.*, 533 U.S. 218, 226-27, 229-30 (2001).

does not merit this Court's deference because it contradicts the clear import of the statute.

Chevron instructs a reviewing court to ask first whether Congress "has directly spoken to the precise question at issue." 467 U.S. at 842. "If the intent of Congress is clear," the Court explained, "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. Only if the statute is "silent or ambiguous" must a reviewing court accept the agency's interpretation, provided that it is "permissible" or "reasonable." *Id.* at 843-44. As discussed, *see* Parts A and B, *supra*, the text and structure of § 1395*oo*(a) and the overall structure of the Medicare Act make clear that the 180-day limit for filing with the Board is jurisdictional. Indeed, because the Court has indicated that it will treat a procedural rule as nonjurisdictional unless Congress has given some "'clear' indication that [it] wanted the rule to be 'jurisdictional,'" *Henderson*, 131 S. Ct. at 1203, any statutory finding requisite to satisfy the Court's jurisdictional test should also satisfy *Chevron*'s first step.

Nor does the agency's embrace of a "good cause" exception offer any persuasive indirect evidence that Congress, in fact, meant § 1395*oo*(a)(3) to be nonjurisdictional.[31] The agencies responsible for imple-

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[31] Quite apart from *Chevron*, the Court will "give an agency's interpretations and practices considerable weight where they involve the contemporaneous construction of a statute and where they have been in long use." *Davis v. United States*, 495 U.S. 472, 484 (1990). This practice presupposes that the views of those charged with implementing a statute—and, thus, most familiar with its political context—may provide at least indirect evidence of what it means. *See, e.g., Andrus v. Shell Oil Co.*,

menting § 1395*oo* have never adopted a clearly articulated or consistently held position that subsection (a)(3) is nonjurisdictional. Rather, the views expressed by the agencies, if anything, tend to provide somewhat greater support for the conclusion that the limitation is jurisdictional. Even though the Secretary adopted the "good cause" exception almost contemporaneously with § 1395*oo*'s enactment, the regulation's statement of basis and purpose neither explained the legal basis for the agency's authority to adopt such an exception nor addressed the question whether § 1395*oo*(a) is jurisdictional. *See* 39 Fed. Reg. 34,515 (Sept. 26, 1974). And, when the agencies responsible for administering the statute have spoken to the jurisdictional status of § 1395*oo*(a) in contexts other than the "good cause" exception, they have routinely interpreted it as a jurisdictional requirement.

The Board, for example, "has consistently treated [§ 1395*oo*(a)'s] three criteria—dissatisfaction, amount in controversy, and timeliness—as jurisdictional requirements." *SKI 1987-1994 DSH SSI% Grp. v. Blue Cross Blue Shield Ass'n*, No. 2009-D12, 2009 WL 981317, at *5 (PRRB Mar. 5, 2009); *see also* notes 12-13, *supra*. And the CMS Administrator—to whom the Secretary has delegated her power to review the Board[32]—has understood the statute similarly. *See, e.g., QRS 96 DSH MediKan Days Grp. v. Blue Cross/Blue Shield Ass'n*, No. 2007-D24, 2007 WL 1804053, at *5 (CMS Adm'r May 25, 2007); *Hemet Valley Med. Ctr.*, No. 2001-D5, 2001 WL 34073897, at *2 (HCFA Adm'r Jan. 31, 2001); *Sacred Heart Med. Ctr. v. Blue Cross & Blue Shield Ass'n*, No. 99-D2, 1998 WL

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446 U.S. 657, 667-68 (1980); *Norwegian Nitrogen Prods. Co. v. United States*, 288 U.S. 294, 314-15 (1933).

[32] *See* note 5, *supra*.

1064771, at *2 (HCFA Adm'r Dec. 21, 1998). At least some of these cases, moreover, have quite plainly used "jurisdiction" in the precise technical sense developed in this Court's post-*Kontrick* case law. In *Marion General Hospital v. Blue Cross & Blue Shield Ass'n*, No. 2007-D8, 2007 WL 1004392 (CMS Adm'r Feb. 12, 2007), for example, CMS made clear that it does not matter when the intermediary interposes a timeliness objection before the Board because "jurisdiction cannot be waived and may be raised at any time." *Id.* at *4 & n.9. Similarly, in cases arising out of the DSH calculation that underpins this litigation, the Board has repeatedly explained that the time limits prescribed by the statute and by the regulations that (purport to) implement it are jurisdictional and not subject to equitable tolling. *See, e.g.*, *Medical Coll. of Georgia Hosp. v. BlueCross BlueShield Ass'n*, No. 2010-D30, 2010 WL 4214222, at *3 (PRRB May 25, 2010), *aff'd*, 2010 WL 5570990 (CMS Adm'r July 13, 2010); *Valley Presbyterian Hosp. v. BlueCross BlueShield Ass'n*, No. 2009-D18, 2009 WL 1973490, at *3 (PRRB Apr. 9, 2009); *SKI 1987-1994*, 2009 WL 981317, at *4.[33]

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[33] In reaffirming that the timeliness requirement is jurisdictional, the Board thus explained that "[t]he time limit for filing is embedded in the legislation establishing the very right to a hearing and clearly indicates Congress' intent that filing within the time specified is a condition precedent to the right to a hearing." *SKI 1987-1994*, 2009 WL 981317, at *5. The Board added that it possesses "only the powers granted to it by statute and regulation" and that "Congress imposed time limits for filing appeals to the Board and did not confer power to apply equitable tolling principles to extend that time." *Id.* at *4. Although the Board relied in part on the Eighth Circuit's decision in *St. Joseph's Hospital v. Heckler*, 786 F.2d 848 (8th Cir. 1986), its position also rested independently on its own reading of the

While HHS regulations did not speak directly to the jurisdictional status of the timeliness requirement until recently, the 2008 amendments make clear that the Secretary interprets § 1395*oo*(a)'s requirements to be jurisdictional. In a provision entitled "Board Jurisdiction," the current regulations specify that, *before* exercising its adjudicatory powers (such as conducting discovery, issuing subpoenas, or holding hearings), "[t]he Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal." 42 C.F.R. § 405.1840(a)(2) (2011). The rule further states that "[t]he Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing ... under § 405.1835 of this subpart." *Id.* § 405.1840(b). Putting to one side the "good cause" exception discussed below (*see* pp. 46-47, *infra*), § 405.1835 merely incorporates and elaborates on the three requirements specified by § 1395*oo*(a). Consistent with well-settled understandings of jurisdictional limitations, the regulations also specify that the Board's preliminary determination of its jurisdiction may be revised "at any subsequent stage of the proceedings." 42 C.F.R. § 405.1840(a)(3) (2011).[34]

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statute and the Secretary's regulations. *See SKI 1987-1994*, 2009 WL 981317, at *5-6.

[34] This Court has long held that a challenge to subject-matter jurisdiction may be raised at any stage of the proceedings. *See, e.g., Mansfield, C. & L.M. Ry. Co. v. Swan*, 111 U.S. 379, 382 (1884). Agency guidance documents confirm the understanding that an objection under § 1395*oo*(a) cannot be waived and can be raised at any time. In the Rules published by the Board to

Although both the Secretary and the Board have now reaffirmed that the requirements of § 1395*oo*(a) are jurisdictional, neither has yet to reconcile the regulatory "good cause" exception with the jurisdictional status of subsection (a)(3). As discussed, this Court's case law makes clear that a jurisdictional requirement is absolute and subject to neither forfeiture, nor waiver, nor equitable tolling. *See* p. 15, *supra*. And because a jurisdictional requirement defines the scope of a tribunal's power, the tribunal lacks authority to relax such a limitation. *See, e.g.*, *Kendall v. United States*, 107 U.S. 123, 125 (1883). The Secretary herself has recognized but not resolved the internal tension in the agency's positions. When the Secretary initiated the latest round of revisions to the implementing regulations, the notice of proposed rulemaking identified the split in the circuits on the status of § 1395*oo*(a)(3) and stated:

> [W]e see some merit to both sides of the split of judicial authority as to our authority to provide for good cause extensions .... Although our proposal to retain and revise these regulations is based primarily on policy considerations, we note that adoption of this proposal may result in additional court decisions and lead to a definitive

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implement § 1395*oo*, Rule 4.4—entitled "Dismissal for Lack of Jurisdiction"—states: "Appeals that fail to meet the jurisdictional requirements will be dismissed. A jurisdictional challenge may be raised at any time during the appeal .... The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements." PRRB, Provider Reimbursement Review Board Rules at 3 (effec. Aug. 21, 2008), *available at* http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/downloads/PRRBRules2008.pdf.

> resolution of whether the regulations are consistent with section [1395*oo*(a)(3)].

69 Fed. Reg. 35,716, 35,725 (June 25, 2004). In the statement of basis and purpose accompanying the new rule, the Secretary offered only the following account of the agency's authority to retain the "good cause" exception:

> [U]nder [42 U.S.C. §§ 1302(a) and 1395hh(a)], which give the Secretary authority to issue regulations for the efficient administration of the Medicare program, we believe we are authorized to provide for discretionary grants and denials of requests to extend the time for requesting a hearing . . . .

73 Fed. Reg. at 30,206.

Of course, an agency's rulemaking authority does not extend beyond the scope of the underlying authority delegated to it by statute, *see, e.g.*, *Lyng v. Payne*, 476 U.S. 926, 937 (1986), and a grant of rulemaking power cannot empower an agency to alter the jurisdictional or nonjurisdictional status of a statutory procedure, *see, e.g.*, *Union Pacific*, 130 S. Ct. at 590; *cf. Kontrick*, 540 U.S. at 452. Thus, the agency has yet to offer a reasoned explanation of how it is possible to treat § 1395*oo*(a)(3) as jurisdictional while simultaneously subjecting it to exceptions nowhere specified by the statute. For the Court to hold that the requirements of § 1395*oo*(a)(3) are jurisdictional, therefore, would not contradict any clearly articulated or consistently held agency understanding of its statutory authority.[35]

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[35] The Secretary's regulations also provide that the Board may reopen its prior decisions, but this set of regulations is con-

sistent with the conclusion that § 1395*oo*(a)(3) is jurisdictional. Within three years after issuing a decision, the Board may reopen that decision "either through [its] own motion . . . or by granting the request of the provider affected by the . . . decision." 42 C.F.R. § 405.1885(a)(2) (2011); *see also id.* § 405.1885(a) (pre-2008 regulation recognizing similar reopening authority). Though less carefully defined, this authority is analogous to the district court's power to reopen a judgment under Federal Rule of Civil Procedure 60(b)—which recognizes and codifies a court's traditional discretion to set aside a final judgment "whose enforcement would work inequity." *Plaut v. Spendthrift Farms, Inc.*, 514 U.S. 211, 233-34 (1998).

Nothing inherent in the authority to grant relief from a final judgment undercuts the time requirements for filing an action (or appeal) in the first instance. To be sure, one could construe a reopening provision in a way that permits the parties to make an end run around such a requirement. For example, if the Board permitted a party, on reopening, to raise novel issues that had not been part of the original appeal and would otherwise be untimely, such an interpretation of the reopening provision might conflict with the spirit, if not the letter, of § 1395*oo*(a). Yet nothing in the reopening regulation compels such an interpretation, and there is at least some indication, in a guidance document, that the responsible agencies understand the need to avoid that outcome. *See* HHS, Medicare Provider Reimbursement Manual—Part 1, § 2931.1(D) ("Issues which were not raised at the Board hearing may not be reopened by the Board."). Indeed, in the context of an intermediary's similar power to reopen an NPR, *see* 42 C.F.R. § 405.1885(a), the federal courts and the Board have taken pains to construe the Secretary's reopening regulations to preserve the efficacy of timely filing requirements, including the one at issue here. *See, e.g.*, *Your Home Visiting Nurse Servs.*, 525 U.S. at 451; *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 620 (D.C. Cir. 1994); *Texas Disproportionate Share v. Various*, No. 95-0800GE, 1996 WL 887660, at *7 (HCFA Adm'r July 22, 1996). Because there is no intrinsic conflict between the reopening provision and strict enforcement of the 180-day timely filing requirement, the mere existence of that reopening provision does not undercut the jurisdictional status of that requirement.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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August 31, 2012

ADDENDUM

STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 1395*oo* provides:

§ 1395*oo*. Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after

filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such

hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's

decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers,

the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

JOINT APPENDIX

No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

JOINT APPENDIX

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CERTIORARI GRANTED: JUNE 25, 2012

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UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115

AUBURN REGIONAL MEDICAL CENTER, ET AL.

v.

KATHLEEN SEBELIUS

DOCKET ENTRIES

DATE	PROCEEDINGS
4/19/2010	US CIVIL CASE docketed. [10-5115]
4/19/2010	NOTICE OF APPEAL filed [1240580] by All Plaintiffs, Auburn Regional Medical Center, Chalmette Medical Center, Doctors Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, Mcallen Medical Center, Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital, UHS Of New Orleans, Universal Health Services, Inc., Valley Hospital Medical Center and Wellington Regional Medical Center seeking review of a decision by the U.S. District Court in 1:07-cv-02075 JDB. Assigned USCA Case Number [10-5115]

* * * * *

DATE	PROCEEDINGS
9/7/2010	*JOINT* APPENDIX [1264351] filed [Volumes: 1] [Service Date: 09/07/2010] [10-5115] (Roth, Robert)
	* * * * *
9/9/2010	APPELLANT BRIEF [1264891] filed by All Plaintiffs, Auburn Regional Medical Center, Chalmette Medical Center, Doctors Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, McAllen Medical Center, Inc., Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital, UHS of New Orleans, Universal Health Services, Inc., Valley Hospital Medical Center and Wellington Regional Medical Center, Inc. [Service Date: 09/09/2010] Length of Brief: 13,786 Words. [10-5115] (Roth, Robert)
9/22/2010	AMICUS FOR APPELLANT BRIEF [1267211] filed by Quality Reimbursement Services [Service Date: 09/22/2010] Length of Brief: 3,095 words. [10-5115] (Lovitky, Jeffrey)
	* * * * *

DATE	PROCEEDINGS
9/22/2010	*CORRECTED* AMICUS FOR APPELLANT BRIEF [1267499] filed by Hospice Advantage, IHG HealthCare, Inc. and Russell-Murray Hospice, Inc. [Service Date: 09/22/2010] Length of Brief: 1,831. [10-5115] (Goldberg, M.)
	* * * * *
10/22/2010	APPELLEE BRIEF [1273332] filed by Kathleen Sebelius [Service Date: 10/22/2010] Length of Brief: 7,079 words. [10-5115] (Marcus, Stephanie)
	* * * * *
11/9/2010	*CORRECTED* APPELLANT REPLY BRIEF [1276386] filed by Auburn Regional Medical Center, Chalmette Medical Center, Doctors Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, McAllen Medical Center, Inc., Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital. UHS of New Orleans, Uni-

DATE	PROCEEDINGS
	versal Health Services, Inc., Valley Hospital Medical Center and Wellington Regional Medical Center, Inc. [Service Date: 11/09/2010] Length of Brief: 6,828 words. [10-5115] (Roth, Robert)
	* * * * *
12/7/2010	ORAL ARGUMENT HELD before Judges Henderson, Griffith and Williams. [10-5115]
6/24/2011	PER CURIAM JUDGMENT filed [1315048] that the judgment of the District Court appealed from in this cause is hereby reversed and the case is remanded for further proceedings for the reasons in the accompanying opinion. Before Judges: Henderson, Griffith and Williams. [10-5115]
6/24/2011	OPINION filed [1315049] (Pages: 10) for the Court by Judge Griffith [10-5115]
	* * * * *
8/8/2011	PETITION filed [1323161] by Appellee Kathleen Sebelius for rehearing, for rehearing en banc. [Service Date: 08/08/2011 by CM/ECF NDA] Pages: 11-15. [10-5115] (Marcus, Stephanie)

DATE	PROCEEDINGS
8/12/2011	CLERK'S ORDER filed [1323944] ORDERED, on the court's own motion, that within 15 days of the date of this order, appellants file a response to the petition for rehearing en banc, not to exceed 15 pages. Absent further order of the court, the court will not accepts a reply to the response. [10-5115]
8/30/2011	RESPONSE FILED [1326634] by All Plaintiffs to petition for rehearing [1323161-2], petition for rehearing en banc [1323161-3] [Service Date: 08/30/2011 by CM/ECF NDA] Pages: 11-15. [10-5115] (Roth, Robert)
12/20/2011	PER CURIAM ORDER, En Banc, filed [1348683] denying petition for rehearing en banc [1323161-3] Before Judges: Sentelle, Henderson, Rogers, Tatel, Garland, Brown, Griffith*, Kavanaugh and Williams*. [10-5115] (A statement by Circuit Judge Griffith, joined by Senior Circuit Judge Williams, concurring in the denial of rehearing en banc is attached)
12/20/2011	Pubiishing Order [1348683-2] [10-5115]
12/20/2011	PER CURIAM ORDER filed [1348708] denying petition for rehearing [1323161-2] Before Judges: Henderson, Griffith* and Williams*. [10-5115] (Circuit Judge Griffith and Senior Circuit Judge Williams

DATE	PROCEEDINGS
	vote to deny the petition for the reasons set forth in their statement concurring in the denial of appellee's petition for rehearing en banc filed December 20, 2011)
12/30/2011	MANDATE ISSUED to Clerk, District Court [10-5115]
	* * * * *
6/25/2012	LETTER filed [1380644] by the Clerk of the Supreme Court of the United States notifying this court of the following activity in the case before it: The petition for writ of certiorari was Granted on 06/25/2012. [10- 5115]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Case No. 1:07-cv-02075-JDB

AUBURN REGIONAL MEDICAL CENTER, ET AL.

v.

MICHAEL O. LEAVITT, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
11/15/2007	1	COMPLAINT against MICHAEL O. LEAVITT (Filing fee $ 350, receipt number 4616008299) filed by EDINBURG REGIONAL MEDICAL CENTER, FOREST HILLS HOSPITAL, FRANKLIN HOSPITAL, HACKENSACK UNIVERSITY MEDICAL CENTER, INLAND VALLEY REGIONAL MEDICAL CENTER, LONG ISLAND JEWISH MEDICAL CENTER, MCALLEN MEDICAL CENTER, NORTHERN NEVADA MEDICAL CENTER RIVER PARISHES

DATE	DOCKET NUMBER	PROCEEDINGS
		HOSPITAL, SOUTHSIDE HOSPITAL, STATEN ISLAND UNIVERSITY HOSPITAL, UHS OF NEW ORLEANS, UNIVERSAL HEALTH SERVICES, INC., VALLEY HOSPITAL MEDICAL CENTER, WELLINGTON REGIONAL MEDICAL CENTER, AUBURN REGIONAL MEDICAL CENTER, CHALMETTE MEDICAL CENTER, DOCTORS HOSPITAL OF STATEN ISLAND. (Attachments: # 1 Exhibit A# 2 Exhibit B# 3 Civil Cover Sheet)(tg,) (Entered: 11/16/2007)
		* * * * *
11/29/2007		Minute Entry. Status Conference held on 11/29/2007 before Judge John D. Bates: Amicus Brief (35 page limit) due by 1/7/2008 in Civil Action 06-1263. Response (25 page limit) due by 2/4/2008.

DATE	DOCKET NUMBER	PROCEEDINGS
		See Order entered on 11/29/07 in Civil Action 06-1263, Baystate Medical Center v. Leavitt, concerning plaintiffs' participation in that case as amicus. (Court Reporter Bryan Wayne) (tb,) (Entered: 11/29/2007)
		* * * * *
2/25/2008		MINUTE ORDER: Upon consideration of 14 defendant's unopposed motion for stay of proceedings, it is hereby ORDERED that the motion is GRANTED; it is further ORDERED that further proceedings in this action are stayed pending this Court's decision on cross-motions for summary judgment in Baystate Medical Center v. Leavitt, Civil Action No. 06–1263; and it is further ORDERED that defendant's time to respond to the complaint is extended until 30 days after the issuance of such decision.

DATE	DOCKET NUMBER	PROCEEDINGS
		Signed by Judge John D. Bates on 2/25/2008. (CK) (Entered: 02/25/2008)
		* * * * *
4/8/2008		MINUTE ORDER: Upon consideration of 15 defendant's unopposed motion for continued stay of proceedings, it is hereby ORDERED that the motion is GRANTED; it is further ORDERED that defendant's time to respond to the complaint is extended until thirty days after the expiration of the deadline for filing an appeal of the Court's March 31, 2008 Memorandum Opinion in Baystate Medical Center v. Leavitt, Civil Action No. 06–1263; and it is further ORDERED that if a cross-appeal is filed in the Baystate action, defendant's time to respond to the complaint is extended until thirty days after the expiration of the deadline for filing

DATE	DOCKET NUMBER	PROCEEDINGS
		the cross-appeal. SO ORDERED. Signed by Judge John D. Bates on 4/8/2008. (CK) (Entered: 04/08/2008)
		* * * * *
4/14/2009	20	MOTION to Dismiss, MOTION to Dismiss for Lack of Jurisdiction by MICHAEL O. LEAVITT (Attachments: # 1 Memorandum in Support, # 2 Text of Proposed Order)(Olson, Lisa) (Entered: 04/14/2009)
		* * * * *
6/16/2009	22	Memorandum in opposition to re 20 MOTION to Dismiss MOTION to Dismiss for Lack of Jurisdiction filed by ALL PLAINTIFFS. (Attachments: # 1 Appendix A–C of Plaintiff's Memorandum in Opposition to Defendant's Motion to Dismiss, # 2 Exhibit A to Plaintiffs' Memorandum in Opposition, # 3 Exhibit B to Plaintiffs' Memorandum in Opposition,

DATE	DOCKET NUMBER	PROCEEDINGS
		# 4 Exhibit C to Plaintiffs' Memorandum in Opposition, # 5 Exhibit D to Plaintiffs' Memorandum in Opposition, # 6 Exhibit E to Plaintiffs' Memorandum in Opposition)(Roth, Robert) (Entered: 06/16/2009)
8/14/2009	23	REPLY to opposition to motion re 20 MOTION to Dismiss MOTION to Dismiss for Lack of Jurisdiction *Defendant's Reply in Support of Motion to Dismiss* filed by MICHAEL O. LEAVITT. (Olson, Lisa) (Entered: 08/14/2009)
		* * * * *
1/21/2010		Minute Entry Motion Hearing held on 1/21/2010 before Judge John D. Bates: re 20 MOTION to Dismiss MOTION to Dismiss for Lack of Jurisdiction filed by MICHAEL O. LEAVITT. Motion heard and taken under advisement. (Court Reporter Bryan Wayne) (tb,) (Entered: 01/22/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
2/19/2010	24	TRANSCRIPT OF PROCEEDINGS before Judge John D. Bates held on 1/21/10; Page Numbers: 1—65. Date of Issuance: 2/19/10. * * *
		* * * * *
2/26/2010	25	MEMORANDUM OPINION. Signed by Judge John D. Bates on 2/26/2010. (ck) (Entered: 02/26/2010)
2/26/2010	26	ORDER granting 20 defendant's motion to dismiss. Signed by Judge John D. Bates on 2/26/2010. (ck) (Entered: 02/26/2010)
3/11/2010	27	AMENDED MEMORANDUM OPINION. Signed by Judge John D. Bates on 3/11/2010. (ck) (Entered: 03/11/2010)
3/11/2010		NOTICE: On the Court's own motion, an Amended Memorandum Opinion has been issued today. The changes in the text are reflected on page 18 of the Amended Memorandum Opinion. The opinion remains the same as 25 the original Mem-

DATE	DOCKET NUMBER	PROCEEDINGS
		orandum Opinion in all other respects, and the holdings reached therein are unaltered. (ck) (Entered: 03/11/2010)
4/16/2010	28	NOTICE OF APPEAL by AUBURN REGIONAL MEDICAL CENTER. Filing fee $ 455, receipt number 0090–2154616. Fee Status: Fee Paid. Parties have been notified. (Roth, Robert) (Entered: 04/16/2010)
		* * * * *
1/3/2012	30	MANDATE of USCA (certified copy) as to 28 Notice of Appeal filed by AUBURN REGIONAL MEDICAL CENTER; ORDERED abd ADJUDGED that the judgment of the District Court appealed from in this cause is hereby reversed and the case is remanded for further proceedings, in accordance with the opinion of the court filed herein this date. USCA Case Number 10–5115. (mmh) (Entered: 01/03/2012)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

No. 1:07-cv-02075-JBD

AUBURN REGIONAL MEDICAL CENTER; CHALMETTE MEDICAL CENTER; DOCTORS' HOSPITAL OF STATEN ISLAND; EDINBURG REGIONAL MEDICAL CENTER; FOREST HILLS HOSPITAL; FRANKLIN HOSPITAL; HACKENSACK UNIVERSITY MEDICAL CENTER; INLAND VALLEY REGIONAL MEDICAL CENTER; LONG ISLAND JEWISH MEDICAL CENTER; MCALLEN MEDICAL CENTER; NORTHERN NEVADA MEDICAL CENTER (F/K/A SPARKS FAMILY HOSPITAL; RIVER PARISHES HOSPITAL; SOUTHSIDE HOSPITAL; STATEN ISLAND UNIVERSITY HOSPITAL; UHS OF NEW ORLEANS; UNIVERSAL HEALTH SERVICES, INC.; VALLEY HOSPITAL MEDICAL CENTER; AND WELLINGTON REGIONAL MEDICAL CENTER, PLAINTIFFS

v.

MICHAEL O. LEAVITT, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

Filed: Nov. 15, 2007

COMPLAINT

Plaintiffs, by and through their undersigned attorneys, bring this action against defendant Michael O. Leavitt, in his official capacity as Secretary of the Unit-

ed States Department of Health and Human Services, and state as follows:

A. Preliminary Statement

1. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§1395 *et seq.* ("the Medicare Act"), and the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 551 *et seq.* The plaintiff-hospitals ("the Hospitals") seek to have their Medicare disproportionate share hospital ("DSH") payment determinations for the fiscal years ("FYs") at issue recalculated because those payment determinations were made using incorrect data. Defendant, the Secretary ("the Secretary") of the Department of Health and Human Services ("HHS"), has refused to consider the Hospitals' requests for relief on the grounds that the Hospitals did not timely file their administrative appeals. Here, however, the time for filing these appeals should be equitably tolled because the Hospitals' failure to file timely appeals was the direct result of the Secretary's knowing and unlawful refusal to inform the Hospitals that the DSH payment determinations at issue were based on incorrect data. Medicare hospitals generally, and the Hospitals specifically, were made aware of these flaws when an administrative decision identifying them was issued in 2006. The Hospitals hereby seek an order stating that the Provider Reimbursement Review Board ("Board" or "PRRB") has jurisdiction over the appeals at issue and remanding this matter to the Board to determine whether correct data was used in the Hospitals' DSH determinations for the FYs at issue in this action.

B. Jurisdiction and Venue

2. This Court has jurisdiction under 42 U.S.C. §1395oo(f) (appeal of final Medicare program agency de-

cision) and 28 U.S.C. §§1331 (federal question) and 1361 (mandamus).

3. Venue lies in this judicial district under 42 U.S.C. §1395oo(f) and 28 U.S.C. §1391.

C. Parties

4. Plaintiffs include Universal Health Services, Inc. ("UHSI") and, except as otherwise noted, the following acute-care hospitals UHSI owns and operates, which furnish inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and which participated in the Medicare program for the FYs listed:

a. Auburn Regional Medical Center (Medicare Provider No. 50-0015), FYs 1987 - 1994.

b. Chalmette Medical Center (Medicare Provider No. 19-0175), FYs 1987 1993. This hospital closed in 2005 in the aftermath of Hurricane Katrina.

c. Edinburg Regional Medical Center (Medicare Provider No. 45-0119), FYs 1990 - 1994.

d. Inland Valley Regional Medical Center (Medicare Provider No. 05-0630), FYs 1987 - 1994.

e. McAllen Medical Center (Medicare Provider No. 45-0016), FYs 1987 1994.

f. River Parishes Hospital (Medicare Provider No. 19-0193), FYs 1987 1993. Although UHSI no longer owns this hospital, it holds the right to Medicare payment for the FYs at issue in this action.

g. Northern Nevada Medical Center (f/k/a Sparks Family Hospital) (Medicare Provider No. 29-0032), FYs 1987 1994.

h. UHS of New Orleans (Medicare Provider No. 19-0175), FYs 1987 1994. This hospital closed in 2005 in the aftermath of Hurricane Katrina.

i. Valley Hospital Medical Center (Medicare Provider No. 29-0021), FYs 1987 1994.

j. Wellington Regional Medical Center (Medicare Provider No. 10-0275), FYs 1987 1994.

5. Plaintiff Franklin Hospital (Medicare Provider No. 33-0372) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1994.

6. Plaintiff Long Island Jewish Medical Center (Provider No. 33-0195) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1994.

7. Plaintiff Forest Hills Hospital (Medicare Provider No. 33-0353) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1994.

8. Plaintiff Southside Hospital (Medicare Provider No. 33-0043) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to,

inter alia, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1994.

9. Plaintiff Hackensack University Medical Center (Medicare Provider No. 31-0001) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1994.

10. Plaintiff Staten Island University Hospital (Medicare Provider No. 33-0160) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1990 and 1993.

11. Plaintiff Doctors' Hospital of Staten Island (Medicare Provider No. 33-0076) is a not-for-profit acute-care hospital that furnishes inpatient and outpatient hospital services to, *inter alia*, patients entitled to benefits under the Medicare program and that participated in the Medicare program for FYs 1987 1989. Staten Island University Hospital owns this hospital, which is now closed.

12. Defendant Michael O. Leavitt is the Secretary of the Department of Health and Human Services, the federal department which contains the Centers for Medicare & Medicaid Services ("CMS"). The Secretary, the federal official responsible for administration of the Medicare Program, has delegated the responsibility to administer that program to CMS. Before June 14, 2001, CMS was known as the Health Care Financing Administration ("HCFA"). In this complaint, plaintiffs refer to

the agency as CMS or HCFA, as appropriate, depending on the context.

D. General Background of the Medicare Program

13. The Medicare Act establishes a system of health insurance for the aged, disabled, and individuals afflicted with end-stage renal disease. Pursuant to 42 U.S.C. §1395cc, each of the Hospitals entered into a written agreement with the Secretary to provide hospital services to eligible individuals.

14. Under 42 U.S.C. §1395x(v)(1)(A), providers of inpatient hospital services, such as the Hospitals, are entitled to payment from Medicare for their "reasonable costs" incurred in providing services to Medicare patients, in accordance with regulations adopted by the Secretary. Reasonable cost is defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services." 42 U.S.C. §1395x(v)(1)(A).

15. In adopting regulations, the statute requires the Secretary to "take into account both direct and indirect costs of providers or services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered." *Id.* The Secretary has elected to publish many rules implementing the Medicare program in various manuals, such as the Provider Reimbursement Manual.

16. Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse hospitals, such as the Hospitals, for inpatient hospital operating costs. *See* 42 U.S.C. §1395ww(d).

17. Payment to providers of services is commonly carried out by Medicare fiscal intermediaries, acting as agents of the Secretary pursuant to contracts with him. An intermediary is assigned to each hospital (including each of the Hospitals) that participates in Medicare. Fiscal intermediaries make periodic payments to providers, subject to subsequent adjustments for overpayments or underpayments. 42 U.S.C. §1395h.

18. At the close of its FY, a hospital must submit a "cost report" showing both the cost incurred by it during the FY and the appropriate portion of those costs to be allocated to, and paid by, Medicare. 42 C.F.R. §§ 413.24 and 413.50. The hospital's intermediary is required to analyze and audit the cost report and issue a Notice of Program Reimbursement ("NPR"), which informs the hospital of the final determination of its Medicare reimbursement for the cost reporting period.

19. If a hospital is dissatisfied with its intermediary's final determination of total Medicare program reimbursement for a cost reporting period, as reflected in the NPR, it may seek to have the NPR corrected or altered in one of two ways:

a. The hospital has a right to obtain a hearing before the Board by filing an appeal with the Board within 180 days of receiving its NPR. 42 U.S.C. §1395oo.

b. The hospital may request reopening of an intermediary's determination within three years of the date of notice to the hospital of the intermediary's determination. 42 C.F.R. §405.1885(a).

20. Regardless whether a hospital files for a Board hearing or seeks reopening, regulations adopted by the Secretary require an intermediary's determination to be reopened within three years of the date of notice of it to the hospital if CMS notifies the intermediary that the determination is in any way "inconsistent with the applicable laws, regulations, or general instructions" issued by CMS. 42 C.F.R. §405.1885(b).

E. Procedure for Administrative and Judicial Review of PRRB Decisions

21. In addition to having the authority to make substantive decisions concerning Medicare reimbursement appeals, under 42 C.F.R. §405.1873, the Board is authorized to decide questions relating to its jurisdiction. The decision of the Board on substantive or jurisdictional issues constitutes final administrative action unless the Secretary reverses, affirms, or modifies the decision within 60 days of the hospital's notification of the Board's decision. 42 U.S.C. §1395oo(f)(1); 42 C.F.R. §§405.1875 and 405.1877. The Secretary has delegated his authority under the statute to review Board decisions to the CMS Administrator.

22. A hospital may obtain judicial review of a final administrative decision, including a decision relating to the jurisdiction of the Board, by filing suit within 60 days of receipt of the decision in the United States District Court for the judicial district in which the hospital is located or in the United States District Court for the District of Columbia. 42 U.S.C. §1395oo(f).

23. The Supreme Court has held that a decision denying a provider's request for reopening under 42 C.F.R. §405.1885(a) is not subject to judicial review. *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1999). However, judicial relief is available under the equitable remedy of mandamus where a hospital has a clear right to the relief sought and the Secretary has a defined and non-discretionary duty to honor that right. *Monmouth Med. Ctr. ("Monmouth") v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001).

F. PPS and the DSH Adjustment

24. Under PPS, Medicare payments for hospital operating costs are not based directly on the costs actually incurred by the hospitals. Rather, they are based on predetermined, nationally applicable rates, subject to certain payment adjustments. 42 U.S.C. §1395ww(d)(1)-(5); 42 C.F.R. Part 412. One of these is known as the "disproportionate share hospital" or "DSH" payment. *See* 42 U.S.C. §1395ww(d)(5)(F).

25. Hospitals that treat a disproportionately large number of low-income patients are entitled by statute to a payment, known as the DSH adjustment, in addition to standard Medicare payments. 42 U.S.C. §1395ww(d)(5)(F). Congress enacted the DSH payment in recognition of the relatively higher costs associated with providing services to low-income patients. These higher costs have been found to result from the generally poorer health of low-income patients. The DSH payment provides additional Medicare reimbursement to hospitals for the increased cost of providing services to low-income Medicare beneficiaries.

26. There are two methods of determining qualification for a DSH adjustment: the "proxy method" (42 U.S.C. §1395ww(d)(5)(F)(i)(I)) and the "Pickle method" (42 U.S.C. §1395ww(d)(5)(F)(i)(II)). The Hospitals' entitlement to a DSH adjustments was determined using the proxy method, under which their entitlement to a DSH adjustment, as well as the amount of the DSH adjustment, is based on the Hospitals' DSH percentage. 42 U.S.C. §1395ww(d)(5)(F)(v) and (vi).

27. The DSH percentage is the sum of two fractions, which are designed to capture the number of low-income patients a hospital serves on an inpatient basis. The first fraction, referred to as the "Medicare Proxy," is intended to account for inpatients who are Medicare beneficiaries entitled to supplementary security income ("SSI"), a federal low-income benefit supplement. The second fraction, referred to as the "Medicaid Proxy," is intended to account for inpatients who are not entitled to Medicare benefits, but who qualify for medical assistance under a State's Medicaid State plan.

28. This action concerns the Medicare Proxy, which is defined as follows under 42 U.S.C. §1395ww(d)(5)(D)(vi)(I):

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and **were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter**, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days)

were entitled to benefits under part A of this subchapter.

(Emphasis added.) The Medicare Proxy, therefore, is the percentage of a hospital's inpatients who received Medicare Part A benefits who were also entitled to SSI benefits when they were receiving inpatient services at the hospital. This is also known as the "SSI percentage."

29. CMS determines the SSI percentage for hospitals that qualify for DSH payment but does not automatically share the underlying data with the affected hospitals. In fact, CMS takes the position that some of the data cannot be given to hospitals. *See* 70 Fed. Reg. 47,440 (August 12, 2005). CMS calculates these percentages using federal fiscal year ("FFY") (October 1 through September 30) data.

30. Section 3-20.3 of the Medicare Claims Processing Manual ("MCPM") requires Medicare fiscal intermediaries to make DSH payment determinations using the SSI percentage supplied to them by CMS. Accordingly, DSH hospitals, such as the Hospitals, do not develop their own SSI percentages. Further, CMS has acknowledged that a provider is not required to claim a DSH payment as part of the formal cost reporting process. *See* 51 Fed. Reg. 31457-58 (September 3, 1986). Rather, Medicare fiscal intermediaries are required to make the proper DSH payment determinations. In accordance with this duty, and the MCPM, the Hospitals' Medicare fiscal intermediaries made the DSH payment determinations at issue in this action using the SSI percentages furnished to them by CMS.

G. Calculation of the SSI Percentage

31. The data used to determine the SSI percentage was addressed in significant detail in the decisions issued by the Board and CMS Administrator in *Baystate Hospital v. Mutual of Omaha Insurance Co. ("Baystate")*, PRRB Case No. 2006-D20 (PRRB Dec. March 17, 2006), *modified* (CMS Adm. Dec. May 11, 2006), complaint filed July 14, 2006 *sub nom Baystate Medical Center v. Leavitt et al.*, 06-cv-1263-JDB (D.D.C. filed July 14, 2006).

32. As explained in the *Baystate* administrative decisions, CMS retrospectively calculates the SSI percentage using data from the June updates of the Medicare Provider Analysis and Review ("MEDPAR") file following the end of the prior FFY. CMS Adm. Dec. at 27.[1] CMS determines these percentages by matching its MEDPAR files of all Medicare claims paid to a hospital during the period with the file maintained by the Social Security Administration ("SSA") of all individuals entitled to SSI benefits during the same period. *Id.* at 16-17. The resulting "match" of these two data sets yields a hospital's number of patient days for the prior FFY that were attributable to hospital patients who were entitled both to Medicare Part A benefits and to SSI benefits under Title XVI of the Social Security Act. This number is divided by the total number of days attributable to patients who were entitled to Medicare Part A benefits, and the final result is the hospital's SSI percentage.

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[1] References in this Complaint to CMS Administrator's Decision in *Baystate* are set forth as "CMS Adm. Dec. at XX," while references to the Board's decision in that appeal are set forth as "Board Dec. at XX."

33. The match process is based on two data sets—an annual data tape from SSA and CMS' MEDPAR file. Each year SSA sends CMS a file that contains the following information for each SSI recipient on the tape: (1) truncated last name and first initial, (2) social security number ("SSN") or railroad retirement program identification number, (3) date of birth, (4) gender, and (5) 42 monthly entries using the "Title II number," which indicates the payment or non-payment of SSI benefits during the period covered by the file. *Id.* at 15-16. The Title II number consists of the SSN of the person whose work history qualified for benefits (the "Title II record holder"), and an alpha-numeric suffix that reflects the relationship between the beneficiary and the Title II record holder. Board Dec. at 13. Because of the various ways of receiving Title II benefits, the Title II number is not necessarily unique to an individual. *Id.*

34. The MEDPAR file contains, for each inpatient stay during the period covered by the file, (1) the hospital's Medicare provider number, (2) the patient's health insurance claim account number ("HICAN"), (3) the dates of admission to and discharge from the hospital, (4) the total inpatient length of stay, (5) the number of days of the stay covered by Medicare Part A, and (6) the number of days in the stay for which the patient was determined to be eligible for SSI benefits, based on CMS' match of SSA and MEDPAR data. CMS Adm. Dec. at 16. CMS generates the HICAN by taking the SSN or railroad retirement number, which may or may not be the beneficiary's own number, from a SSI record generated by CMS and an alpha-numeric beneficiary identification code. Board Dec. at 15.

35. CMS accomplishes the matching process by attempting to match the HICAN contained in the

MEDPAR file to the Title II number from the SSA file. *Id.* Patient days that are matched as a result of this process are included in the numerator of the Medicare Proxy for purposes of determining a hospital's DSH payment. In general, the more days that are counted in the numerator of the Medicare proxy, the greater the hospital's DSH payment.

H. Flaws in the SSI Percentage Identified in *Baystate* Board Decision

36. The Board's decision in *Baystate* included some background and identified many flaws concerning CMS' calculation of the SSI percentage, and CMS' awareness of these flaws.

37. CMS requires PPS hospitals to use the SSI percentages that CMS provides. "42 C.F.R. 412.106(b) provides that CMS will calculate a hospital's Medicare fraction. . . . " Board Dec. at 6. "[T]he DSH statute directs CMS to determine the SSI fraction. . . . " *Id.* at 8.

38. CMS has known for many years that its SSI percentages were incorrect for many FYs, including the ones at issue in the *Baystate* appeal, because the agency was aware that (1) the process it used to match beneficiary specific information with SSA data to determine the SSI percentage was flawed and (2) several problems existed with data used to determine the SSI percentage.

a. "Both parties consistently acknowledged during the hearing that the Social Security number is the best unique identifier. However, despite CMS' stated intent to use Social Security numbers as the patient match criteria, the evidence showed that CMS has never matched Social Security numbers on the SSI

data tape with Social Security numbers on the MEDPAR in the calculation of the SSI ratios." *Id.* at 12-13.

b. "[I]ndividuals who received a forced payment during their inpatient stays were not shown as having been entitled to SSI for such periods on SSA annual tapes. Shafer [a CMS employee] testified that forced payments were a common occurrence during the periods at issue here. Thus, the omission of all these records was a systematic and recurring error that had the effect of understating the SSI ratios." *Id.* at 26.

c. CMS should have known that the omission of retroactive SSI awards was a problem. "CMS' 1996 summary report showed that the ratio of the number of stays with new SSI days added . . . to the number of stays with old SSI days deleted . . . was greater than 17:1 for most years." Theoretically, and as CMS claimed, the two categories could have offset each other resulting in a wash. Yet, with the ratio at 17:1, the stays with new SSI days added were not offset by any countervailing situation. *Id.* at 28.

d. CMS knew that stale records were a problem with SSI fractions. Yet, in a June 1995 proposed rule to change the process of recalculation of the SSI ratio based on a hospital's cost reporting period, CMS claimed that the result of recalculating the ratio was "invariably" lower SSI ratios due to problems with the hospital's data. Five months later CMS requested corrected SSI records from SSA because its MEDPAR records were contaminated. CMS created a set of "special" MEDPAR files to allow CMS

to determine the number of hospital stays in which the value of the SSI days increased or decreased. It subsequently used these special MEDPAR files for "everything" and claims that, even though it possessed these tapes as late as 1997, it either lost or destroyed those records. *Id.* at 33-34.

e. "The uncontroverted evidence shows that the CMS knew, at least by 1993, that there was a problem with the SSI data that CMS had been receiving from SSA." *Id.* at 25.

39. CMS never revealed these flaws to PPS hospitals and made false or misleading statements, which induced PPS hospitals into believing that the SSI percentages were correct when, in fact, they actually were incorrect.

a. CMS made false representations in a proposed and final rule "that SSA, not CMS computes the SSI fractions, and that SSA does not release the underlying data to CMS." *Id.* at 34.

b. CMS knew that its "record retention failures" made it impossible for hospitals to demonstrate the financial impact caused by the flaws in the process. *Id.* at 32.

c. CMS published misleading information about whether it counted HMO days in the SSI fraction. CMS published a notice in the Federal Register September 4, 1990 that it had been counting HMO days in the SSI fraction since 1987, but CMS' MEDPAR programmer, Mr. Dean, testified that the field on MEDPAR for HMO days "hasn't been used since the time that I started running MEDPAR" in 1995." *Id.* at 39-40.

40. In *Loma Linda Community Hospital v. Shalala*, 907 F. Supp. 1399 (C.D. Cal. 1995), a DSH hospital sought to recalculate its SSI percentage based on its independent evaluation of the data on which the percentage should have been based and brought its dispute to the Board. The court ruled that the hospital was entitled to determine its SSI factor independently and recognized its right to obtain access to the underlying data used by CMS in calculating the applicable SSI percentage.

I. **Equitable Tolling**

41. The federal government may only be sued if Congress has "unequivocally expressed" its intention to waive the sovereign's immunity. *Irwin v. Veterans Admin. ("Irwin")*, 498 U.S. 89, 95 (1990). That waiver may address not only what action can be redressed through the lawsuit but also how and when the action must be brought. In general, a lawsuit against the federal government where Congress has waived sovereign immunity must be brought within the time frame set forth in the congressional waiver.

42. Equitable tolling extends the time for such an action to be brought. In *Irwin*, the Supreme Court addressed whether equitable tolling is applicable to lawsuits against the federal government or whether the time to bring an action against the federal government may only be extended by an "unequivocal expression" from Congress. The issue before the Court, therefore, was whether equitable tolling could, in effect, broaden "the congressional waiver" of sovereign immunity, by allowing a lawsuit to be bought beyond the time limit established by Congress. *Id.*

43. The Supreme Court held that "making the rule of equitable tolling applicable to suits against the Government, in the same way that it is applicable to private suits, amounts to little, if any, broadening of the congressional waiver." *Id.* The Court went on to state that equitable tolling "should also apply to suits against the United States" and that Congress "may provide otherwise if it wishes to do so." *Id.* at 96. Since *Irwin* was decided, Congress has made no effort to "provide otherwise." Accordingly, there is no question that equitable tolling is available to those seeking to bring an otherwise untimely action against the United States.

44. Under the holding in *Irwin* and other cases, there also is no question that equitable tolling is applicable to regulatory filing deadlines, including deadlines for filing Medicare administrative appeals. *See, e.g., Bradford Hospital v. Shalala ("Bradford")*, 108 F. Supp. 2d 473 (W.D. Pa. 2000).

45. Four years before *Irwin* was decided, the Supreme Court found in *Bowen v. City of New York ("City of New York")*, 476 U.S. 467 (1986), that Congress had explicitly allowed for equitable tolling to apply in Medicare cases by including language in 42 U.S.C. § 405(g) providing that civil actions against the Secretary must filed "within sixty days . . . or within such further times as the Secretary may allow." By allowing the Secretary to extend the filing deadline, the Court found that Congress had expressed the "clear intention to allow tolling in some cases." *City of New York*, 476 U.S. at 480.

46. The Supreme Court also found that the 60-day filing requirement under 42 U.S.C. §405(g) is not "jurisdictional, but rather is a statute of limitations waivable

by the parties." *Id.* at 476. The 180-day filing period for Board appeals in 42 U.S.C. §1395oo(a) is similarly not jurisdictional. The Secretary has, in fact, conceded this point by adopting a regulation, 42 C.F.R. §405.1841(b), which explicitly allows the 180-day filing period to be waived. *Ozark Mountain Reg'l Rehab. Ctr., Inc. v. HHS,* 798 F. Supp. 16 (D.D.C. 1992).

47. In *Irwin,* the Court specifically stated that equitable tolling is available "where the complainant has been induced or tricked by his adversary's misconduct in allowing the filing deadline to pass." *Irwin,* 498 at 96.

48. When considering whether equitable tolling applies to this action, this Court should be mindful of the concern expressed by the Supreme Court that this Court not "assume the authority to narrow the waiver that Congress intended." *City of New York,* 476 U.S. at 479. The Court also should be mindful of the prohibition of "cross-subsidization" under 42 U.S.C. § 1395x(v)(1)(A), which requires the Secretary to "take into account both direct and indirect costs of providers or services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered." In order for the Hospitals to be properly paid, so that their Medicare patients are not cross-subsidized by non-Medicare patients in violation of 42 U.S.C. §1395x(v)(1)(A), the SSI percentage used must be correct, which did not occur.

49. Because the Board found in *Baystate* that DSH payments were improperly calculated, the rejection of equitable tolling would violate the cross-subsidization

bar and, also, would impermissibly narrow the waiver of sovereign immunity that Congress explicitly intended.

J. Facts Applicable to the Hospitals

50. For the FYs at issue in this action, the Medicare fiscal intermediaries for each of the Hospitals made a determination about whether the Hospitals were entitled to a DSH payment and, if so, the amount of that payment. When making these determinations, the intermediaries were required to use, and is understood by the Hospitals to have used, the SSI percentage supplied to them by CMS.

51. The DSH determinations were made by the Hospitals' Medicare fiscal intermediaries without regard to whether the Hospitals requested a DSH payment. This is because CMS has acknowledged that a Medicare-participating hospital is not required to claim a DSH payment as part of the formal cost reporting process. *See* 51 Fed. Reg. 31457-58 (September 3, 1986). Rather, intermediaries are required to make the proper DSH payment determinations.

52. On or about September 12, 2006, the Hospitals appealed their DSH payment determinations for the FYs at issue to the Board on the grounds that they were made using an understated SSI percentage ("the DSH-SSI Issue"). Five of the Hospitals filed individual appeals (Hackensack University Medical Center—PRRB Case No. 06-2296; Long Island Jewish Medical Center—PRRB Case No. 06-2352; Forest Hills Hospital—PRRB Case No. 06-2354; Franklin Hospital—PRRB Case No. 06-2355, and Southside Hospital—PRRB Case No. 06-2356). Two of the Hospitals, Staten Island University Hospital and Doctors' Hospital of Staten Island, filed a Group Appeal (Crowell & Moring 97-93 DSH/SSI Equi-

table Tolling Group Appeal—PRRB Case No. 06-2357G). The remaining ten Hospitals[2] filed a separate Group Appeal (UHS 87-94 DSH/SSI Equitable Tolling Group Appeal—PRRB Case No. 06-2359G).

53. Each of these seven appeals was filed more than three years after the Medicare NPRs had been issued for each of the FYs at issue, but within 180 days of the issuance of the Board's decision in *Baystate*. *See* 42 U.S.C. §1395oo.

54. When filing their appeals to the Board, the Hospitals noted that the Board has authority under 42 C.F.R. §405.1841(b) to extend the time for filing an appeal for up to three years after the issuance of the NPR for "good cause," but that this regulation did not apply because the NPRs at issue had been issued more than three years before the appeal was filed. Accordingly, the Hospitals asked the Board to find that this appeal is timely filed under the principle of equitable tolling, citing several authorities, including *Bradford*, *supra*, where (1) the Board applied the principle of equitable tolling to extend a Medicare filing deadline and (2) the court found that equitable tolling applies to deadlines for filing Medicare administrative appeals.

55. The Hospitals further explained that the Board should find that equitable tolling applies because the Hospitals' failure to file a timely appeal on the DSH-SSI Issue was the direct result of CMS's knowing and unlawful refusal to inform hospitals paid under Medicare PPS,

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[2] Auburn Regional Medical Center, Chalmette Medical Center, Edinburg Regional Medical Center, Inland Valley Regional Medical Center, McAllen Medical Center, River Parishes Hospital, Northern Nevada Medical Center, UHS of New Orleans, Valley Hospital Medical Center, and Wellington Regional Medical Center.

such as the Hospitals, that their SSI percentages were incorrectly understated for the FYs at issue. This is clear from the Board's decision in *Baystate*, where the Board reversed the government's flawed SSI percentage determination and remanded the case to the Medicare fiscal intermediary to recalculate that determination in accordance with the Board's decision.

56. Hospitals generally, and the Hospitals specifically, were made aware of these flaws when the *Baystate* decision was issued.

57. The Board dismissed the Hospitals' appeals without a hearing, issuing substantively identical decisions in each of the seven appeal. *See, e.g.*, PRRB Decision in UHS 87-94 DSH/SSI Equitable Tolling Group Appeal—PRRB Case No. 06-2359G (Exhibit A). The Board dismissed the appeals on the grounds that it lacked jurisdiction because the appeals were not timely filed, stating "there is no dispute that the request for hearing was not made within three years of the issuance of the NPRs." *See, e.g.*, Exhibit A at 3. The Board also stated that it "does not have general equitable powers and cannot grant equitable relief such as equitable tolling." *Id.* These decisions violated the APA because, *inter alia*, they were not made in accordance with law.

58. In a letter dated November 1, 2007 (Exhibit B), the CMS Administrator declined to review the Board's decisions in these seven appeals and acknowledged that (a) the Board's September 18, 2007 decisions are the Secretary's final decisions for purposes of judicial review and (b) judicial review of the Board's decisions is available.

COUNT I

59. Plaintiffs hereby incorporate by reference paragraphs 1 through 58 herein.

60. The Board's decisions holding that it lacks jurisdiction over the appeals at issue in this action were unlawful under the APA and other authority. These decisions must be reversed because (a) the Board and the Secretary have the authority to grant equitable tolling relief and (b) the Hospitals were entitled to such relief with respect to the DSH-SSI Issue for the FYs at issue in this action as the Hospitals' failure to file these appeals within the time limits set forth in 42 U.S.C. §1395oo was the direct result of CMS's knowing and unlawful refusal to inform the Hospitals that their SSI percentages were incorrectly understated for these FYs. Accordingly, plaintiffs are entitled to an order stating that the Board has jurisdiction over the appeals at issue and remanding them to the Board to determine whether the correct SSI percentages were used in the DSH payment determinations that were made with regard to the Hospitals for the FYs at issue in this action.

COUNT II

61. Plaintiffs hereby incorporates paragraphs 1 through 60 herein.

62. The Hospitals' Medicare fiscal intermediaries have the non-discretionary duty to use correct SSI percentages when determining whether the Hospitals were entitled to DSH payments for the FYs at issue in this action, and the amount of any DSH payments due. Accordingly, plaintiffs are entitled to issuance of a writ of mandamus under the Medicare Act, the *Monmouth* decision, and other authority requiring the Secretary to

order the Hospitals' Medicare fiscal intermediaries, or their successors in interest, to make new DSH determinations for the FYs at issue in this action using correct SSI percentages.

COUNT III

63. Plaintiffs hereby incorporate by reference paragraphs 1-62 herein.

64. The Hospitals' Medicare fiscal intermediaries must use correct SSI percentages when determining whether the Hospitals were entitled to DSH payments for the FYs at issue in this action, and the amount of any DSH payments due. Accordingly, under the All Writ's Act, 28 U.S.C. §1651, and other authority, plaintiffs are entitled to issuance of an order requiring the Secretary to order the Hospitals' Medicare fiscal intermediaries, or their successors in interest, to make new DSH determinations for the FYs at issue in this action using correct SSI percentages.

K. Requested Relief

WHEREFORE, plaintiffs request:

1. An order stating that the Board has jurisdiction over the appeals at issue in this action and remanding this matter to the Board to determine whether the correct SSI percentages were used in the Hospitals' DSH payment determinations for the FYs at issue;

2 The issuance of a writ of mandamus requiring the Secretary to order the Hospitals' Medicare fiscal intermediaries, or their successors in interest, to make new DSH determinations for the FYs at issue in this action using correct SSI percentages;

3. An order requiring the Secretary to order the Hospitals' Medicare fiscal intermediaries, or their successors in interest, to make new DSH determinations for the FYs at issue in this action using correct SSI percentages;

4. Legal fees and costs of suit incurred by plaintiffs; and

5. Such other relief as this Court may consider appropriate.

Respectfully submitted,

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APPENDIX A

1. "Both parties consistently acknowledged during the hearing that the Social Security number is the best unique identifier. However, despite CMS' stated intent to use Social Security numbers as the patient match criteria, the evidence showed that CMS has never matched Social Security numbers on the SSI data tape with Social Security numbers on the MEDPAR in the calculation of the SSI ratios." Compl. at 38.a.; Board Dec. at 12-13.

(a) Mr. Anthony Dean, CMS' principal MEDPAR programmer, contradicted himself extensively regarding which elements CMS uses to match the SSA tapes with the MEDPAR. Mr. Dean testified on multiple occasions that CMS only uses the HICAN. However, at the Board hearing, he contradicted his earlier testimony by testifying that CMS matches on both the Title II number and an equated Social Security Number. PRRB Hearing Transcript ("PRRB Hearing Tr.") (Exhibit E) at 1340-1360.

(b) Mr. Dean also testified that matching an individual's SSN from the SSA's tapes against an individual's SSN from CMS' data would produce a better match than attempting to match a SSN to a HICAN. *Id.* at 1395:4-24.

(c) Mr. Alan Shafer, a SSA employee for more than thirty years, testified that matching patient records solely on the Title II number is a "systemic error" in the SSI ratio calculation and that such errors will always fail to identify an SSI stay. *Id.* at 404:14-16; 20-25.

2. "[I]ndividuals who received a forced payment during their inpatient stays were not shown as having been entitled to SSI for such periods on SSA annual tapes. Mr. Shafer testified that forced payments were a common occurrence during the periods at issue here. Thus, the omission of all these records was a systematic and recurring error that had the effect of understating the SSI ratios." Compl. at 38.b.; PRRB Dec. at 26.

(a) Mr. Shafer testified that the impact of the omission of forced pay cases on the calculation of the Medicare fraction would always understate that fraction. PRRB Hearing Tr. at 339:14-23. However, such errors could be easily fixed with a simple software change. *Id.* at 339:24-340:14.

(b) Mr. Stephen Phillips, a former CMS technical advisor for the Acute Care Hospital Division, testified that individuals on the SSI rolls who are not receiving a cash SSI payment for a particular period should be counted in the numerator of the SSI fraction. *Id.* at 1173:21-1174:2.

(c) Mr. Dean was unable to state how the matching program would handle a situation where three records would appear on the SSA tapes due to a force pay situation. He could only say that two of the three records would be eliminated, but could not say whether the record which showed the beneficiary was actually entitled to SSI benefits would be the record the program kept. PRRB Hearing Tr. at 1380:9-1381:3.

(d) Ms. Ann Tayloe, one of the principal persons responsible for CMS' Medicare DSH policy during the time relevant to this action, testified she could not recall what kinds of days are included in either

the numerator or of the denominator of the DSH percentage. *Id.* at 2010:16-18; 2011:17-2012:10; 2014:12-20.

3. CMS should have known that the omission of retroactive SSI awards was a problem. Compl. at 38.c.

(a) "CMS' 1996 summary report showed that the ratio of the number of stays with new SSI days added . . . to the number of stays with old SSI days deleted . . . was greater than 17:1 for most years." Theoretically, and CMS claimed as much, the two categories could have offset each other resulting in a wash. Yet, with the ratio at 17:1, the stays with new SSI days added were not offset by any countervailing situation. Board Dec. at 28.

(b) Mr. David Pfeil, a Medicare DSH consultant, testified that retroactive benefit changes captured by the tapes produced by the SSA resulted in approximately 17 additional cases for every 1 case that was deleted. PRRB Hearing Tr. at 1575:11-17.

4. CMS knew that stale records were a problem with SSI fractions. Yet, in a June 1995 proposed rule to change the process of recalculation of the SSI ratio based on a hospital's cost reporting period, CMS claimed that the result of recalculating the ratio was "invariably" lower SSI ratios due to problems with the hospital's data. Compl. at 38.d. Five months later CMS requested corrected SSI records from SSA because its MEDPAR records were contaminated. CMS created a set of "special" MEDPAR files to allow CMS to determine the number of hospital stays in which the value of the SSI days increased or decreased. It subsequently used these special MEDPAR files for "everything" and claims that, even though it possessed these tapes as late

as 1997, it either lost or destroyed those records. Board Dec. at 33-34. Mr. Daryl Rosenberg testified that the special MEDPAR files had "disappeared" by being written over, and there was "no way of finding out" how many times the tapes had been written over. PRRB Hearing Tr. at 2085:20-2086:3; 2086:19-2087:7; 2098:10-12.

5. "The uncontroverted evidence shows that the CMS knew, at least by 1993, that there was a problem with the SSI data that CMS had been receiving from SSA." Complaint at 38.e.; Board Dec. at 25.

(a) Mr. Pfeil testified that, after he contacted CMS in 1993, CMS made "no attempt to look at what was causing the problem" with the data CMS was using to calculate hospitals' PRRB Hearing Tr. at 1519:20-1920:12.

(b) Ms. Rosenberg testified that prior to hearing from Mr. Pfeil in 1993, CMS was already aware of a problem with the data it was using to calculate the SSI fraction. *Id.* at 2130:24-2131:14.

(c) Despite CMS' awareness that the SSI data was flawed, Mr. Phillips testified that CMS never retroactively adjusted providers' SSI ratios to account for the problems caused by the omission of stale beneficiary records from the SSA's tapes. *Id.* at 1148:22-1149:4.

(d) Several witnesses testified that Ms. Tayloe would have been involved in any decision to go back and correct prior calculations of the SSI fraction once corrected tapes were received from SSA that included the stale records. *See* Testimony of Ms. Janet O'Leary, former branch chief of the Nation-

al Claims History Branch, PRRB Hearing Tr. at 693:14-694:8; Phillips, *Id.* at 1149:19-22; Rosenberg, *Id.* at 2053:6-12. However, Ms. Tayloe could not recall whether or not she was involved in this decision. *Id.* at 1933:13-1934:2.

(e) Mr. Dean testified that later MEDPAR runs would include more complete and accurate data. *Id.* at 1385:16-23.

(f) Mr. Phillips agreed that the latest available data was the "best" available data that CMS has, but despite running an update on the MEDPAR file every quarter, CMS never published more than one SSI fraction for a federal fiscal year. *Id.* at 1167:1-7; 1169:4-10.

APPENDIX B

1. CMS made false representations in a proposed and final rule "that SSA, not CMS computes the SSI fractions, and that SSA does not release the underlying data to CMS." Compl. at 39.a.; Board Dec. at 34. Ms. Tayloe testified that the statements in the proposed and final rules that SSA computes the SSI fractions, were incorrect. PRRB Hearing Tr. at 1987:10-1989:5.

2. CMS knew that its "record retention failures" made it impossible for hospitals to demonstrate the financial impact caused by the flaws in the process. Compl. at 39.b.; Board Dec. at 32.

(a) In response to interrogatories, CMS stated it could not answer questions regarding the number of SSI days included and reflected in the special MEDPAR files, because it had no such files. Further, CMS was unable to provide identifying details about lost or destroyed files, such as the type, content, length, and who may have knowledge of the circumstances under which files were lost or destroyed. Despite being designated by CMS as the person responsible for answering these questions, Ms. O'Leary testified that neither she nor anyone else she was aware of had done anything to look for these files or the identifying information about them. PRRB Hearing Tr. at 755:21-756:3; 813:10-814:3.

(b) According to Mr. Rosenberg's testimony, the data on the tapes had "disappeared" by being written over, and there was "no way of finding out" how many times the tapes had been written over. *Id.* at 2085:20-2086:3; 2086:19-2087:7; 2098:10-12.

(c) Mr. Dean testified that he had several years worth of old SSA tapes that he kept under his desk, but they were destroyed, probably in 1997 or 1998, because there was no need for them and no direction to keep them. *Id.* at 1397:2-22; 1398:15-21; 1399:8-17.

3. CMS published misleading information about whether it counted HMO days in the SSI fraction. Compl. at 39.c. CMS published a notice in the Federal Register September 4, 1990 that it had been counting HMO days in the SSI fraction since 1987, but CMS' MEDPAR programmer, Mr. Dean, testified that the field on MEDPAR for HMO days "hasn't been used since the time that I started running MEDPAR" in 1995." Board Dec. at 39-40.

(a) Mr. Dean testified that the MEDPAR field for HMO days had not been used since he began running the MEDPAR, and that he did not believe the field was even populated. PRRB Hearing Tr. at 1387:3-1388:1.

(b) Ms. Tayloe testified that HMO days were considered covered days for the purposes of the DSH calculation. PRRB Hearing Tr. at 1921:14-21.

APPENDIX C

1. Ms. Patricia Cribbs, the SSA employee responsible for creating the annual SSI tapes sent to CMS from 1988 to 2004, testified that CMS never provided her with, nor was she aware of, any written data specifications or systems requirements for producing the SSI tapes and that she never participated in any testing or validation of the data included on the tapes. PRRB Hearing Tr. at 111:23-112:18; 116:18-117:19; 123:24-124:11.

2. Ms. Tayloe stated she did not understand the mechanics of the data exchange between SSA and CMS. *Id.* at 1924:1-7. She also testified that, to her knowledge, the only assurance CMS received for purposes of making sure the match process was accurate and complete was a single meeting with Ms. Cribbs. *Id.* at 1989:19-1990:8; 1991:21-1922:9.

3. Ms. Tayloe also testified that she (i) did not know how retroactive SSI eligibility status was treated for purposes of counting days for the Medicare DSH fraction, (ii) did not understand how the process for matching SSA data to the MEDPAR was accomplished, and (iii) did not know whether it was possible for a beneficiary to receive both a federal and a state payment at the same time. *Id.* at 2021:12-25; 2023:15-22; and 2026:2-11.

4. Ms. O'Leary, former branch chief of the National Claims History Branch, the branch responsible for matching SSA's data with the MEDPAR, was not aware of any federal standards for software development applicable to the matching process used to create the SSI ratios. *Id.* at 758:18-759:3.

5. Mr. Dean testified that he had no guidelines or correspondence or instructions from either CMS or SSA that related to matching the data. PRRB Hearing Tr. at 1353:18-1354:12.

6. Mr. Dean, also testified that he had no records of any testing he had done on the matching process, and that whatever testing he did do did not identify the omission of stale records from the SSA tapes, the omission of force-pay cases from the SSA tapes, and would not identify records in which a beneficiary had more than one Title II number. *Id.* at 1363:10-25; 1368:11-1369:6. He also testified he had never visited with Ms. Cribbs, his counterpart at SSA, to look at the data she uses to create the SSA tapes or to verify or validate how SSA generates the tapes. *Id.* at 1374:18-24.

7. Mr. Shafer testified CMS' process calculating providers' SSI fractions did not conform to Federal Information Processing Standards for recurring processes with programmatic payments. *Id.* at 410:23-413:3.

PETITIONER'S BRIEF

No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTIONS PRESENTED

1. Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. 1395*oo*(a)(3), is subject to equitable tolling.

2. Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. 1395*oo*(a)(3), may be extended for any period.

PARTIES TO THE PROCEEDING

Petitioner is Kathleen Sebelius, Secretary, United States Department of Health and Human Services.

Respondents are Auburn Regional Medical Center, Chalmette Regional Medical Center, Doctors' Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, McAllen Medical Center, Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital, UHS of New Orleans, Universal Health Services, Inc., Valley Hospital Medical Center, and Wellington Regional Medical Center.

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In the Supreme Court of the United States

No. 11-1231

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-10a) is reported at 642 F.3d 1145. The order of the court of appeals denying rehearing en banc (Pet. App. 63a-64a), and an opinion concurring in the denial of rehearing (Pet. App. 65a-66a), are reported at 685 F.3d 1059. The amended opinion of the district court (Pet. App. 11a-50a) is reported at 686 F. Supp. 2d 55. The decision of the Administrator of the Centers for Medicare & Medicaid Services declining to review the decisions of the Provider Reimbursement Review Board (Pet. App. 57a-58a) is unreported. The decisions of the Provider Reimbursement Review Board (*e.g.*, Pet. App. 51a-56a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 24, 2011. Petitions for rehearing were denied on December 20, 2011 (Pet. App. 61a-66a). On March 13, 2012, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including April 13, 2012, and the petition was filed on that date. The petition was granted on June 25, 2012. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions are set forth in an appendix to this brief. App., *infra*, 1a-33a.

STATEMENT

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* (Medicare Act), pays for certain medical services provided to elderly and disabled patients entitled to benefits under the program. Part A of the program provides insurance for covered inpatient hospital and related post-hospital services. Under the Prospective Payment System (PPS), hospitals providing inpatient Medicare services are paid at a fixed amount for each patient discharged, regardless of actual costs incurred. 42 U.S.C. 1395ww(d) (2006 & Supp. IV 2010).

Hospitals and other Part A providers submit cost reports at the end of each fiscal year to contractors, known during the relevant time period as fiscal intermediaries, which are generally private insurance companies acting on behalf of the Department of Health and Human Services (HHS). See 42 U.S.C. 1395h; 42 C.F.R.

405.1801(b)(1), 413.1(a)(2), 413.20(b), 413.24(f).[1] The fiscal intermediary determines the total payment due and issues a Notice of Program Reimbursement (NPR), informing the provider how much it will be paid for the fiscal year at issue. 42 C.F.R. 405.1803.

a. As originally enacted, the Medicare Act did not provide for any administrative or judicial review of the fiscal intermediary's payment determination. See H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (1971) (*1971 House Report*); S. Rep. No. 1230, 92d Cong., 2d Sess. 51 (1972). Pursuant to agreements, the intermediary itself provided certain review procedures, but there was no process for appealing to the Secretary.[2] See *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 349, 350 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977); *1971 House Report* 108. On May 27, 1972, HHS formalized those procedures in regulations promulgated through notice-and-comment rulemaking. The regulations afforded providers an opportunity to request a hearing before an intermediary hearing officer if (1) the provider was dissatisfied with the intermediary's payment determination; (2) the amount in controversy was $1000 or more; and (3) the request was filed within 60 days after issu-

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[1] Unless otherwise indicated, all references to Title 42 of the Code of Federal Regulations are to the 2007 version. As relevant here, subsequent amendments to Part 405, Subpart R, 42 C.F.R. 405.1801 *et seq.*, apply only to "appeals pending as of, or filed on or after[,] August 21, 2008." See 73 Fed. Reg. 30,190 (May 23, 2008). Accordingly, those amended regulations do not directly apply to this case. See Pet. App. 15a n.3.

[2] At that time, fiscal intermediaries entered into contracts with the Secretary of the Department of Health, Education, and Welfare (HEW), which was HHS's predecessor agency. References to the "Secretary" throughout the brief are either to the Secretary of HEW or the Secretary of HHS, depending on the relevant time period.

ance of the NPR. See 37 Fed. Reg. 10,724 (adopting 20 C.F.R. 405.492(a) (1973)). If the provider's request for a hearing was untimely, the intermediary hearing officer was required to dismiss the request—unless the provider could demonstrate "good cause" and the request was filed within three years of the NPR. See *ibid.* (adopting 20 C.F.R. 405.493 (1973)); see also *id.* at 10,725 (adopting 20 C.F.R. 405.499g (1973)) (providing for, *inter alia*, discretionary reopening "within 3 years" of the NPR).

Shortly thereafter, Congress enacted legislation establishing an administrative and judicial review process governing provider payment under the Medicare Act. See Social Security Amendments of 1972 (1972 SSA Amendments), Pub. L. No. 92-603, § 243(a), 86 Stat. 1420 (42 U.S.C. 1395*oo*).[3] To effectuate the new statutory scheme, the Secretary was charged with establishing a Provider Reimbursement Review Board (PRRB or Board). 42 U.S.C. 1395*oo*(a). The Board was to be composed of five members "appointed by the Secretary" and "knowledgeable in the field of payment of providers of services"; two of the members were to be "representative of providers of services" and one "a certified public accountant." 42 U.S.C. 1395*oo*(h).

In 1974, after notice and comment, the Secretary published regulations implementing Section 1395*oo*. See 39 Fed. Reg. 34,514 (Sept. 26, 1974) (final rule); 39 Fed. Reg. 8166 (Mar. 4, 1974) (proposed rule). The final rule included, in modified form, the intermediary-hearing regulations promulgated two years prior, 39 Fed. Reg. at 34,515, as well as newly promulgated (though often-

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[3] Initial legislative proposals to afford providers an opportunity to appeal an adverse payment determination by a fiscal intermediary dated back to the 91st Congress. See S. Rep. No. 1431, 91st Cong., 2d Sess. 176-177 (1970).

times similar) regulations governing Board hearings, *id.* at 34,517-34,519.

b. Under the review scheme established by Section 1395*oo* and the Secretary's regulations, a provider that has filed a timely cost report is entitled to a hearing before the PRRB "if" the provider is dissatisfied with the final determination of the intermediary; the amount in controversy is $10,000 or more; and the request is filed within 180 days of the NPR. 42 U.S.C. 1395*oo*(a)(1)(A)(i), (2) and (3); see 42 C.F.R. 405.1835(a)-(b), 405.1839(a), 405.1841(a)(1). A provider is also entitled to a hearing "if" the intermediary's final determination is not rendered within 12 months after receipt of the provider's cost report; the amount in controversy requirement is met; and the request is filed within 180 days after the determination would have issued had it been timely rendered. 42 U.S.C. 1395*oo*(a)(1)(B)-(C), (2) and (3); see 42 C.F.R. 1835(c), 1841(a)(1). And a provider is entitled to a hearing "if" it is dissatisfied with the Secretary's determination of the "amount of payment" to be received during a fiscal year under the PPS. 42 U.S.C. 1395*oo*(a)(1)(A)(ii). Again, the amount in controversy requirement must be met and the request must be filed within 180 days of the Secretary's final determination. 42 U.S.C. 1395*oo*(a)(2) and (3); see 42 C.F.R. 405.1801(a)(3), 405.1835(a)-(b), 405.1839(a), 405.1841(a)(1). The statute and regulations additionally allow group appeals by providers raising the same legal or factual issues, if the amount in controversy is $50,000 or more in the aggregate and the providers satisfy the other criteria for an individual appeal. 42 U.S.C. 1395*oo*(b); see 42 C.F.R. 405.1837.

Pursuant to a regulation first adopted in 1974, "[a] request for a Board hearing filed after the [180-day time

limit] shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider." 42 C.F.R. 405.1841(b); cf. 42 C.F.R. 405.1813 (parallel good-cause exception for intermediary hearings).

That regulation was amended in 2008 to further specify and narrow the circumstances in which an extension may be granted. See 42 C.F.R. 405.1836 (2011). As amended and recodified, the regulation now provides that "[t]he Board may find good cause * * * only if the provider demonstrates * * * [that] it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike)." 42 C.F.R. 405.1836(b) (2011). The request must be "received by the Board within a reasonable time" after "expiration" of the 180-day limit, and the Board may not grant an extension request if received "later than 3 years after" the NPR. 42 C.F.R. 405.1836(b) and (c)(2) (2011). The Board is also prohibited from granting an extension for good cause if "[t]he provider relies on a change in the law, regulations, [Rulings of the Centers for Medicare & Medicaid Services (CMS)],[4] or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the

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[4] CMS is the component of HHS that administers the Medicare program for the Secretary. CMS was formerly the Health Care Financing Administration (HCFA). The Secretary has delegated her review authority to the Administrator of HCFA (now CMS). 49 Fed. Reg. 35,248 (Sept. 6, 1984). For ease of reference, this brief refers to both components interchangeably as CMS.

extension request." 42 C.F.R. 405.1836(c)(1) (2011). A finding "that the provider did or did not demonstrate good cause * * * is not subject to judicial review." 42 C.F.R. 405.1836(e)(4) (2011).

The Board has the authority to affirm, modify, or reverse the final determination of the intermediary. 42 U.S.C. 1395*oo*(d). The Board also has "full power and authority to make rules and establish procedures, not inconsistent with the provisions of [the Medicare Act] or regulations of the Secretary, which are necessary and appropriate to carry out the provisions of [Section 1395*oo*]." 42 U.S.C. 1395*oo*(e); see 42 C.F.R. 405.1867. The decision of the Board is final unless the Secretary reverses, affirms, or modifies it within 60 days. 42 U.S.C. 1395*oo*(f)(1). A provider may seek judicial review of "any final decision of the Board," or of "any reversal, affirmance, or modification by the Secretary," by filing suit in federal district court within 60 days. *Ibid.* That suit is governed by the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.* 42 U.S.C. 1395*oo*(f)(1).

Apart from the administrative appeal process, a provider may also obtain administrative relief from an intermediary's final payment determination by requesting that the intermediary "reopen" its determination. See 42 C.F.R. 405.1885(a). The provider's request "must be made within 3 years of the date of the [NPR]," and "[n]o [intermediary] determination * * * may be reopened after such 3-year period." *Ibid.*[5] An interme-

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[5] The reopening regulation requires the reopening of an intermediary's determination beyond the three-year period "if it is established that such determination * * * was procured by fraud or similar fault of any party to the determination." 42 C.F.R. 405.1885(d). Because neither the Secretary nor CMS nor the intermediary is a "par-

diary's denial of a provider's reopening request is not subject to administrative review by the PRRB or to judicial review. See *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 452-457 (1999).

2. The PPS provides for certain payment adjustments based on hospital-specific factors. One such add-on is available to hospitals "serv[ing] a significantly disproportionate number of low-income patients," referred to as a "disproportionate share hospital," or "DSH," adjustment. 42 U.S.C. 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the Medicare DSH adjustment and the amount of any such adjustment depend on the particular hospital's "disproportionate patient percentage." 42 U.S.C. 1395ww(d)(5)(F)(v).

The disproportionate patient percentage for a given hospital is the sum of two components, commonly known as the "Medicaid" fraction and the "Medicare/SSI" or "SSI" fraction. See 42 U.S.C. 1395ww(d)(5)(F)(vi). The Medicaid fraction reflects the number of hospital inpatient days attributable to patients eligible for medical assistance under a state Medicaid plan, but not entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The numerator consists of the number of hospital inpatient days for patients eligible for Medicaid but *not* entitled to Medicare Part A; the denominator consists of all hospital inpatient days. *Ibid.* The SSI fraction, at issue in this case, reflects the number of hospital inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. 42 U.S.C.

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ty" to the fiscal intermediary's determination, reopening under that subsection is required only when the provider (or a related organization of the provider) has itself "procured" the determination by "fraud or similar fault." 42 C.F.R. 405.1805, 405.1885(d).

1395ww(d)(5)(F)(vi)(I).[6] The numerator consists of the number of hospital inpatient days for patients entitled to Medicare Part A *and* SSI; the denominator consists of all hospital inpatient days for patients entitled to Medicare Part A. *Ibid.*

Computation of the SSI fraction requires the matching of individual Medicare billing records (submitted to CMS by the hospital) to individual SSI records (maintained by the Social Security Administration (SSA)). During the relevant time period, "the data sources for the computation of the SSI fraction included approximately 11 million billing records from the Medicare inpatient discharge file, and over 5 million records from the SSI file compiled by SSA." *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, 23 (D.D.C.), amended in part, 587 F. Supp. 2d 37 (D.D.C. 2008) (*Baystate*). For that reason, it was determined that CMS would calculate the SSI fraction for each hospital. *Ibid.*; 42 C.F.R. 412.106(b)(2). CMS provides the SSI fraction to the responsible intermediary; the intermediary then calculates the Medicaid fraction based on data submitted by the provider and, using both fractions, determines the disproportionate patient percentage. 42 C.F.R. 412.106(b)(4)-(5).

3. This case arises against the background of litigation brought by Baystate Medical Center (Baystate), which is not a party to this action. Baystate timely appealed its DSH adjustment determinations by the intermediary for fiscal years 1993 through 1996, and challenged CMS's calculation of the numerator of the SSI

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[6] The SSI program is a federal assistance program, administered by the Social Security Administration, for low-income individuals who are aged, blind, or disabled. See 42 U.S.C. 1381 *et seq.*; *Sullivan* v. *Zebley*, 493 U.S. 521, 524 (1990).

fraction. On appeal, the Board concluded, among other things, that the SSI data used to calculate the SSI fraction were incomplete or inaccurate in certain respects; that there were flaws in the data-matching process; and that those errors "tended to deflate the overall DSH payment," Pet. App. 17a-18a. See *Baystate Med. Ctr.*, PRRB Dec. No. 2006-D20, 2006 WL 752453, at *33-*34 (Mar. 17, 2006). The CMS Administrator (Administrator) reversed the Board's decision, in relevant part, and affirmed CMS's determination of the SSI fraction. See *Baystate Med. Ctr.*, 2006 WL 1684639 (CMS Adm'r May 11, 2006). The district court, in turn, concluded that CMS did not rely on the "best available data" to compute the SSI fraction, and it reversed, in part, the Administrator's decision. See 545 F. Supp. 2d at 57-58.

4. Each of the respondent hospitals in this case received NPRs, which included determinations regarding their DSH adjustments, for fiscal years between 1987 and 1994. J.A. 17-19, 34 ¶¶ 4-11, 50, 52. In contrast to Baystate, respondents did not appeal those determinations to the Board within 180 days. See 42 U.S.C. 1395*oo*(a)(3); Pet. App. 17a. Nor did they seek a discretionary extension of the 180-day deadline within three years for "good cause shown," 42 C.F.R. 405.1841(b), or request reopening by the intermediary within three years, 42 C.F.R. 405.1885(a). See Pet. App. 18a, 29a & n.9, 45a, 52a, 55a.

In September 2006, nearly six months after the Board's *Baystate* decision and more than a decade after the statutory appeal deadlines had expired, respondents attempted to appeal the intermediaries' determinations of their DSH adjustments. Pet. App. 2a, 18a.[7] Re-

[7] Several of the respondents filed individual appeals, and others filed group appeals. See J.A. 34 ¶ 52. Because the Board's decisions

spondents acknowledged that their appeals to the Board were untimely, but urged that equitable tolling was appropriate "because the hospitals' failure to file an appeal within 180 days of issuance of the NPRs was the result of CMS's refusal to inform the hospitals that their SSI percentages were incorrectly understated for the fiscal years at issue." *Id.* at 18a-19a. In respondents' view, "the appeals were timely [under an equitable-tolling theory] because they were filed within 180 days of the Board's *Baystate* decision." *Id.* at 19a.

The Board dismissed respondents' appeals, concluding that it lacked jurisdiction to decide them. Relying in part on its earlier decision in *Anaheim Memorial Hospital*, PRRB Dec. No. 2000-D72, 2000 WL 1146514 (July 3, 2000), the Board held that it could not grant "equitable relief" such as "equitable tolling." Pet. App. 55a. The Board explained that it "is an administrative forum and, unlike the courts, [it] does not have general equitable powers but rather only the powers granted to it by statute and regulation." *Ibid.* The Secretary, acting through the Administrator, declined to review the Board's decision. *Id.* at 57a-58a.

5. Respondents then filed this action arguing, among other things, that the Board should have equitably tolled the 180-day appeal deadline. See J.A. 31-37. The district court held, *inter alia*, that the Medicare Act does not authorize equitable tolling of the 180-day administrative appeal period, and granted the government's motion to dismiss. Pet. App. 11a-50a.

6. The court of appeals reversed. Pet. App. 1a-10a. Relying on *Irwin* v. *Department of Veterans Affairs*, 498

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are substantively the same, the appendix to the certiorari petition contains a representative decision in one of the group appeals. See Pet. App. 51a-56a; J.A. 36 ¶ 57.

U.S. 89 (1990), the court applied a presumption that equitable tolling is available. Pet. App. 5a-6a. The court reasoned that such a presumption was appropriate because, *inter alia*, a hospital's claim for payment under the Medicare Act is "familiar to private litigation," in which tolling is generally available, "because it is analogous to a contract claim." *Id.* at 5a-6a & n.1 (citation omitted).

The court of appeals then concluded that the presumption had not been rebutted. Contrasting Section 1395*oo*(a)(3) with the statutory time limit for tax refund claims at issue in *United States* v. *Brockamp*, 519 U.S. 347 (1997), the court observed that, here, the statutory language is "fairly simple"; there are no statutory exceptions; and the timing provision is not itself complex. Pet. App. 9a-10a. The court recognized that there is a "good cause" exception provided under the Secretary's regulations, but concluded that the regulatory exception is immaterial to the equitable-tolling inquiry and, in any event, not sufficiently technical to rebut the presumption. *Id.* at 9a. The court also acknowledged that the Medicare Act "is quite complex," but nevertheless concluded that Section 1395*oo*(a)(3) is "amenable to tolling" because "its timing scheme is straightforward." *Id.* at 10a. The court therefore held that the 180-day period for requesting a Board hearing is subject to equitable tolling, and remanded to the district court for "further factual development" to determine whether tolling is "appropriate" in this case. *Ibid.*

SUMMARY OF ARGUMENT

The Secretary of Health and Human Services and the Court-appointed amicus curiae agree on the most fundamental point: the 180-day administrative appeal deadline in Section 1395*oo*(a)(3) is not subject to judi-

cially imposed equitable tolling. In the view of the Secretary, the Medicare Act grants her authority to determine whether and when to allow the Board to extend the filing deadline, and her considered judgment of the limits to be imposed on the Board's authority to do so must be respected by the courts. In the view of amicus, neither the courts nor the Secretary can extend the filing deadline for any reason. Either way, the court of appeals' decision must be reversed.

A. The Secretary has broad authority to interpret and implement Section 1395*oo*. Through notice-and-comment rulemaking contemporaneous with the enactment of that section, the Secretary determined that the Board has no authority to hear untimely appeals filed beyond the 180-day deadline in 42 U.S.C. 1395*oo*(a)(3), except as provided by regulation: for "good cause" shown *if* the request is filed within three years of the NPR. 42 C.F.R. 405.1841(b), 405.1867. An equitable-tolling regime superimposed on the long-established procedures for provider appeals under Medicare would conflict with the limitations in the Secretary's regulation. The court of appeals' decision to do so contravenes settled principles of administrative law, which preclude courts from imposing extra-statutory procedural requirements on an administrative tribunal, see *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978), and from setting aside a duly promulgated regulation that is neither arbitrary nor capricious.

B. Neither precedent nor logic suggests that the Court should apply a presumption in favor of equitable tolling to a statutory deadline governing an administrative appeal scheme of the sort at issue here. That presumption should not override fundamental principles of administrative law. Any presumption is, moreover, inap-

plicable here on its own terms because a provider's claim for Medicare payment is not comparable to any suit that can be brought against a private litigant in federal court. And, even if it were to apply, any such presumption would be substantially weakened in this context, where equitable principles do not traditionally govern the substantive law and where Congress enacted the time deadline eighteen years before this Court's decision in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990).

In any event, a presumption in favor of equitable tolling would be rebutted here because the statutory text, structure, and history, and the underlying subject matter and purpose, make clear that Congress did not authorize courts to engraft an open-ended equitable tolling exception onto Section 1395*oo*(a)(3). The 180-day time limit in the statute does not contain its own exceptions that could be enforced directly by a court. From the Board's inception, the Secretary has consistently prohibited it from extending that deadline, except as provided by regulation. For nearly four decades, Congress has acquiesced in that interpretation. An equitable-tolling regime would place substantial administrative burdens on the agency, its contractors, and on the Medicare Trust Fund that Congress did not envision and could not have intended.

C. The Secretary agrees with the Court-appointed amicus curiae that the courts have no authority to engraft extra-textual equitable exceptions onto Section 1395*oo*(a)(3). She also agrees that the 180-day deadline is in some sense "jurisdictional," in that it constrains the Board's authority to adjudicate a provider's appeal. The Secretary, however, parts company with amicus on one issue: her authority to promulgate a regulation estab-

lishing the scope of the Board's jurisdiction within the administrative review process and allowing an extension of the 180-day appeal period in limited circumstances. In the Secretary's view, the Board's adjudicatory authority is defined by statute and by regulation, but not by the courts.

ARGUMENT

THE 180-DAY TIME LIMIT FOR A PROVIDER TO APPEAL TO THE PROVIDER REIMBURSEMENT REVIEW BOARD IS NOT SUBJECT TO EQUITABLE TOLLING

Respondents contend (and the court of appeals held) that the 180-day statutory time limit for a provider to file an administrative appeal with the Board is like an ordinary statute of limitations for filing a suit in court and for that reason is subject to judicially fashioned principles of equitable tolling. Br. in Opp. 13, 14-21; Pet. App. 5a-10a. The Court-appointed amicus curiae, by contrast, argues that the 180-day administrative appeal period is a jurisdictional limit on the PRRB's adjudicatory authority and cannot be extended for *any* reason, even pursuant to the Secretary's "good cause" regulation. Amicus Br. 14-47. As is often the case, the answer lies somewhere in between.

The Secretary stands at the center of the exceedingly complex statutory and regulatory program that governs Medicare claims, processing, and payment. The comprehensive and self-contained administrative and judicial review scheme that governs provider payment is also a product of both statute and regulation. The 180-day administrative appeal deadline is a critical part of that scheme, and the Secretary's implementing regulations reinforce the importance of timely filing and of finality. The Secretary determined, after notice and comment, that an extension of the 180-day filing period

could be warranted, but only if requested within three years and only if "good cause" is shown.

Judicially imposed equitable tolling is inconsistent with that statutory and regulatory review scheme. As we argue below and as respondents do not dispute, the Secretary had authority to promulgate the good-cause regulation. Her considered judgment that an extension of the 180-day period should be permitted *only* in the limited circumstances allowed by that regulation is entitled to substantial deference and cannot be overridden unless arbitrary and capricious. The regulation is plainly valid under that standard, and open-ended equitable tolling is therefore inconsistent with the statute as implemented by the Secretary. But if the Court were to conclude that the Secretary did not have authority to permit *any* extensions (as amicus argues), a court likewise has no authority to craft equitable exceptions. Accordingly, although the Secretary and amicus disagree about whether the Secretary has authority to craft any exceptions to the 180-day filing deadline, they agree on the most fundamental point: a court does not have authority to do so through imposition of judicially fashioned equitable-tolling principles on the Board's administrative procedures. The court of appeals' unprecedented decision to the contrary, rendered after almost 40 years of established practice since the enactment of 42 U.S.C. 1395*oo*, should be reversed.

A. Well-Established Principles Of Administrative Law Preclude Equitable Tolling Of The 180-Day Administrative Appeal Deadline

Fundamental principles of administrative law preclude courts from imposing extra-statutory procedural requirements on an administrative tribunal and from setting aside a regulation, duly promulgated through

notice-and-comment rulemaking pursuant to an express grant of rulemaking authority, that is neither arbitrary nor capricious. The equitable-tolling regime imposed on the Board by the court of appeals violates both precepts.

1. a. When a statutory deadline addresses matters to be resolved by an administrative agency, the implementation of that deadline is entrusted to agency discretion. "[T]he very basic tenet of administrative law [is] that agencies should be free to fashion their own rules of procedure." *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 543-544 (1978) (*Vermont Yankee*); see *FCC* v. *Pottsville Broad. Co.*, 309 U.S. 134, 143 (1940). While "[a]gencies are free to grant additional procedural rights in the exercise of their discretion, * * * reviewing courts are generally not free to impose them if the agencies have not chosen to grant them." *Vermont Yankee*, 435 U.S. at 524. The reason for affording agencies procedural autonomy is simple: "administrative agencies and administrators will be familiar with the industries which they regulate and will be in a better position than federal courts or Congress itself to design procedural rules adapted to the peculiarities of the industry and the tasks of the agency involved." *Id.* at 524-525 (quoting *FCC* v. *Schreiber*, 381 U.S. 279, 290 (1965)). When an agency adopts procedural rules pursuant to a statutory grant of rulemaking authority to implement a program entrusted to it for administration, those procedures are entitled to substantial deference and they cannot be set aside unless they are arbitrary, capricious, or contrary to law. See *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 21 (2000) (*Illinois Council*); *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 417-418 (1993); *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990); *Commodity Futures Exch.*

Comm'n v. *Schor*, 478 U.S. 833, 844 (1986); *Heckler* v. *Chaney*, 470 U.S. 821, 832 (1985); *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837, 843-844 (1984).

Those well-established principles apply with particular force to the statutory and regulatory regime governing Medicare. As this Court has often recognized, the Medicare program is exceedingly "complex and highly technical," and its administration requires "significant expertise," as well as "the exercise of judgment grounded in policy concerns." *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (*Thomas Jefferson*) (citation omitted); see *Illinois Council*, 529 U.S. at 13 (describing Medicare program as "a massive, complex health and safety program * * *, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations"). The Secretary has broad rulemaking authority to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under [Medicare]." 42 U.S.C. 1395hh(a)(1); accord 42 U.S.C. 1302(a); 42 U.S.C. 1395ii (incorporating 42 U.S.C. 405(a)). That includes the authority to adopt rules and procedures to govern the administrative appeal process. See *Illinois Council*, 529 U.S. at 20-21; *Weinberger* v. *Salfi*, 422 U.S. 749, 763-767 (1975). Section 1395*oo* itself confers broad authority on the Secretary with respect to the Board: the Secretary establishes the Board and appoints its members, see 42 U.S.C. 1395*oo*(a) and (h); she may review its decisions, 42 U.S.C. 1395*oo*(f)(1); and the Board may adopt its own rules and procedures only if they are "not inconsistent" with the Medicare Act or "regulations of the Secretary," 42 U.S.C. 1395*oo*(e).

b. Pursuant to that broad rulemaking authority, the Secretary, following notice and comment, promulgated

regulations to implement Section 1395*oo*. See 39 Fed. Reg. at 34,514, 34,515 (final rule); 39 Fed. Reg. at 8166 (proposed rule). The regulations (as first promulgated and as amended) set forth detailed criteria for filing a group appeal (42 C.F.R. 405.1837), calculating the amount in controversy (42 C.F.R. 405.1839), requesting a Board hearing (42 C.F.R. 405.1841), disqualifying Board members (42 C.F.R. 405.1847), scheduling and conducting a Board hearing (42 C.F.R. 405.1849-.1861), and issuing a decision (42 C.F.R. 405.1871). The regulations specify the parties to a Board hearing (42 C.F.R. 405.1843), the composition of the Board (42 C.F.R. 405.1845), and the scope of the Board's decision-making authority (42 C.F.R. 405.1869).

With respect to the administrative appeal deadline, the regulations provide that a request for a Board hearing must be filed "within 180 days" of the intermediary's issuance of the NPR, 42 C.F.R. 405.1841(a)(1), and that a request filed after 180 days "shall be dismissed" unless the provider demonstrates "good cause" for an extension and the request is made no more than three years after the NPR, 42 C.F.R. 405.1841(b). The three-year limit on that narrow exception to the 180-day appeal period, as in effect when respondents sought review by the Board, is emphatic:

> A request for a Board hearing filed after the [180-day time limit] *shall be dismissed* by the Board, except that for good cause shown, the time limit may be extended. However, *no such extension shall be granted* by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

Ibid. (emphases added); accord 42 C.F.R. 405.1836(b)-(c) (2011). Indeed, a parallel provision governing hearings

before a fiscal intermediary preceded the creation of the Board, see 37 Fed. Reg. at 10,724 (adopting 20 C.F.R. 405.493 (1973)), and remains in effect, 42 C.F.R. 405.1813 (2011). Cf. 37 Fed. Reg. at 10,725 (adopting 20 C.F.R. 405.499g (1973)) (reopening regulation); 42 C.F.R. 405.1885(a) (2011) (current reopening regulation). The regulation governing the 180-day filing period for appeals to the Board and allowance of an extension only for good cause was promulgated in 1974. See 39 Fed. Reg. at 34,514; pp. 5-6, *supra*. It has remained in effect ever since, and was amended in 2008 to specify and further narrow the circumstances in which an extension may be granted. See pp. 6-7, *supra*. Since 1974, Congress has amended Section 1395*oo* six times, without altering the 180-day administrative appeal period or the Secretary's rulemaking authority, and without overriding the three-year outer time limit adopted by the Secretary for an extension upon a showing of "good cause." See *Schor*, 478 U.S. at 846.[8]

c. The Board and the Administrator have consistently held that the Board has no inherent authority to toll the 180-day appeal deadline for equitable reasons. That conclusion necessarily follows from the Act itself, which provides that the Board may adopt its own procedures only if they are "not inconsistent with the [Medicare

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[8] See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13503(c)(1)(B), 107 Stat. 579; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4161(a)(6) and (b)(4), 104 Stat. 1388-94, -95; Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, Div. B, Tit. III, §§ 2351(a)(1) and (b)(1), 2354(b)(39) and (40), 98 Stat. 1098, 1099, 1102; Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(h), 97 Stat. 165; Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, Tit. IX, § 955, 94 Stat. 2647; Act of Oct. 26, 1974, Pub. L. No. 93-484, § 3(a), 88 Stat. 1459.

Act] or regulations of the Secretary." 42 U.S.C. 1395*oo*(e); see 42 C.F.R. 405.1867. And as explained above, the Secretary's regulations *prohibit* the Board from granting a request for a hearing filed more than 180 days after an NPR issues *unless* the provider can demonstrate good cause for the delay *and* the request is filed within three years. See 42 U.S.C. 1395*oo*(a)(3); 42 C.F.R. 405.1841(a)(1) and (b). Deference to an agency's interpretation of its own regulation is required unless it is contrary to the plain language of the regulation, particularly where, as here, "the regulation concerns 'a complex and highly technical regulatory program.'" *Thomas Jefferson*, 512 U.S. at 512 (citation omitted).

In *Anaheim Memorial Hospital*, PRRB Dec. No. 2000-D72, 2000 WL 1146514 (July 3, 2000) (*Anaheim*), the Board explained that "it does not have general equitable powers," but only those "powers granted to [it] by statute and regulation." *Id.* at *13. The Board observed that, to the extent applicable, the good-cause and reopening regulations provide "limited regulatory authority to grant relief from time limits in factual situations that could constitute grounds for equitable tolling." *Id.* at *15.[9] But, the Board explained, outside of the specific circumstances identified in those regulations it has no residual authority to "grant equitable relief such as equitable tolling." *Id.* at *13. The Board (and the Administrator) have reiterated that interpretation in a number of subsequent adjudications, including in the decisions below. See, *e.g.*, *Medical Coll. of Ga. Hosp.*, PRRB Dec. No. 2010-D30, 2010 WL 4214222, at *3 (May 25, 2010), aff'd, 2010 WL 5570990, at *3 (CMS

[9] Since the decision in *Anaheim*, the regulation has been revised to expressly set forth a narrow definition of "good cause." See pp. 6-7, *supra*.

Adm'r July 13, 2010); *Valley Presbyterian Hosp.*, PRRB Dec. No. 2009-D18, 2009 WL 1973490, at *3 (Apr. 9, 2009); *SKI 1987-1994 DSH SSI% Group*, PRRB Dec. No. 2009-D12, 2009 WL 981317, at *4 (Mar. 5, 2009) (*SKI Group*); Pet. App. 51a-56a.[10]

d. Rather than respecting the Secretary's considered judgment, the court of appeals engrafted a judge-made exception onto that carefully crafted administrative review scheme, imposing its own open-ended procedural rule of equitable tolling. Cf. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 455 (1999) (*Your Home*) (describing the reopening regulation as providing an appropriate "procedure" for making retroactive corrective adjustments). The court thereby granted providers a right to seek an untimely Board hearing by the simple expedient of invoking judicially fashioned notions of equitable tolling, requiring a fact-intensive inquiry broader than the agency's own assessment of "good cause." See *Credit Suisse Sec. (USA) LLC* v. *Simmonds*, 132 S. Ct. 1414, 1419 (2012) (*Credit Suisse Sec.*); 42 C.F.R. 405.1836(b) (2011). In so doing, the court of appeals impermissibly intruded on the Secretary's discretion to determine the rules and procedures

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[10] The Board and the Administrator have similarly held that the Board lacks authority to equitably toll certain regulatory deadlines. See *Newman Mem. County Hosp.*, PRRB Dec. No. 2001-D41, 2001 WL 1023208, at *11 (Aug. 20, 2001) (180-day regulatory time limit for requesting exception to routine cost limit); *Mercy Gen. Hosp.*, PRRB Dec. No. 2000-D87, 2000 WL 1460704, at *11 (Sept. 22, 2000) (same); cf. *Bradford Reg'l Med. Ctr.*, PRRB Dec. No. 99-D19, 1999 WL 10149, at *8 (Jan. 9, 1999) (90-day time limit for submitting supporting documentation relating to capital-related costs), rev'd, 1999 WL 398034, at *12-*14 (HCFA Adm'r Mar. 12, 1999), rev'd, *Bradford Hosp.* v. *Shalala*, 108 F. Supp. 2d 473 (W.D. Pa. 2000).

governing the Board. See *Vermont Yankee*, 435 U.S. at 524.

Importing an equitable-tolling regime into an administrative appeals process that has functioned appropriately for almost four decades would also work a fundamental shift in the agency's operations at every level. Under the current administrative review scheme, the Board must simply dismiss all appeals filed more than 180 days after the NPR, unless the provider can demonstrate good cause for the delay. See 42 C.F.R. 405.1836(a) (2011); see also 42 C.F.R. 405.1841(a)(1) and (b). And it must in all events dismiss any hearing request filed more than three years after the NPR. See 42 C.F.R. 405.1836(c)(2) (2011); see also 42 C.F.R. 405.1841(b). Under these governing standards, an intermediary need only inform the Board that a hearing request is untimely or, in certain circumstances, respond to a provider's request for an extension for good cause under the regulation. 42 C.F.R. 405.1843(a) (2011); CMS, *Medicare: Provider Reimbursement Manual*, Pt. 1, ch. 29, § 2900(B)(6)(b), at 29-6 (2011) (*PRM*).[11] The Secretary (acting through the Administrator) may review good-cause extensions granted or denied by the Board when appropriate. See 42 C.F.R. 405.1836(e)(2)-(3), 405.1875 (2011); see also, *e.g.*, *St. Joseph Reg'l Health Ctr.*, 2007 WL 1004399 (CMS Adm'r Feb. 6, 2007) (*St. Joseph*). But otherwise, CMS has little (if any) involvement in the administrative adjudication of untimely claims. See 42 C.F.R. 405.1843(b) (2011). And a finding "that the provider did or did not demonstrate good cause * * * is not subject to judicial review." 42

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[11] http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html (last visited Sept. 10, 2012).

C.F.R. 405.1836(e)(4) (2011); cf. *Your Home*, 525 U.S. at 452-457 (denial by intermediary of request to reopen not subject to administrative or judicial review); but see *Western Med. Enters., Inc.* v. *Heckler*, 783 F.2d 1376, 1380-1381 & n.3 (9th Cir. 1986).

In practice, then, HHS currently need not devote significant resources to adjudicating or litigating untimely appeals. This Office has been informed by HHS that no good-cause extensions of the appeal deadline have been granted under the regulation as amended in 2008, see 42 C.F.R. 405.1836 (2011), and that, under the prior version, the Board found good cause to extend the deadline in approximately three dozen appeals from 1986 through 2007.[12] In three of those cases, the Board's decision was reversed by the Administrator. See *St. Joseph*, 2007 WL 1004399, at *4-*6; *St. Vincent's Hosp. FY 1986 Outlier Group*, 2000 WL 1146583, at *2-*10 (HCFA Adm'r Jan. 3, 2000); *Independent Outlier Group II*, 1999 WL 649069, at *3-*9 (HCFA Adm'r July 23, 1999).

Affording providers a new procedural right to invoke equitable tolling to override that carefully circumscribed statutory and regulatory framework would fundamentally alter the treatment of untimely appeals at great cost to the agency, to the Medicare program, and to the Medicare Trust Fund. Under an equitable-tolling régime, the Board could no longer dismiss untimely appeals outright (or, for those filed within three years of the NPR, after a limited inquiry into good cause, espe-

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[12] HHS has informed this Office that, to compile the data, the PRRB searched its electronic case management system, which includes records for cases dating back to 1986, as well as certain earlier cases that were still open in 1988-1989 when the system was manually updated.

cially as now narrowly defined), but instead would have to consider in every instance whether the provider had established more open-ended equitable grounds for the late filing. "[T]he Board is burdened by an immense caseload," and "procedural rules requiring timely filings are indispensible devices for keeping the machinery of the reimbursement appeals process running smoothly." *High Country Home Health, Inc.* v. *Thompson*, 359 F.3d 1307, 1310 (10th Cir. 2004) (*High Country*).

For intermediaries, which appear as parties before the Board to defend their NPRs, 42 C.F.R. 405.1843(a), the availability of equitable tolling would mean an entirely new docket of stale cases, in which they would have to inquire into and defend against arguments for equitable tolling. If equitable tolling were then allowed, intermediaries would have to defend payment claims on their merits for cost years that had long since been closed. CMS too would have additional responsibilities, both before the Board (actively participating in Board hearings where, as here, the provider's equitable-tolling arguments are based on CMS's actions), and in court (litigating untimely claims). Beyond the increased caseload, CMS and intermediaries would have to confront the challenges of defending against stale claims when documents and records may no longer exist (pursuant to valid record-retention policies), when witnesses may be unavailable, and when memories have faded. The courts, in turn, would experience an increased number of cases raising equitable-tolling arguments and seeking adjudication of stale claims on their merits.

e. The scenario illustrated by this case vividly demonstrates why HHS declined to confer broader authority on the Board to equitably toll the 180-day appeal deadline. One provider (here, Baystate) brings a *timely*

appeal challenging one aspect of its final payment determination (here, calculation of the numerator of the SSI fraction for purposes of computing the DSH adjustment) for one or more cost reporting years (here, 1993 through 1996). That provider argues that it is entitled to additional payment for those cost years because the underlying data were flawed, or there was a mathematical error in making the calculations, or the agency misinterpreted the statutory formula. The Board or a reviewing court agrees with that one provider and remands for the intermediary to recalculate that provider's payment amount for the challenged cost reporting years. Hundreds of other providers then learn of the Board (or court) decision and believe that the intermediary may have used similarly flawed data, or calculations, or interpretations to calculate their payment for cost reporting years that have long since been closed. They then file *untimely* appeals with the Board invoking equitable tolling.

This case, for example, is only the first of more than a dozen post-*Baystate* suits in the District Court for the District of Columbia filed on behalf of approximately 200 hospitals for more than 2000 fiscal years—all invoking equitable tolling and relying on *Baystate* to seek recalculation of payment determinations made many years (and oftentimes, as in this case, a decade or more) ago. See Pet. App. 11a-12a; App., *infra*, 34a-37a. Hospice providers raising other payment issues have similarly invoked equitable tolling in suits currently pending in federal court. App., *infra*, 34a-37a. And HHS informs this Office that approximately 450 providers have invoked equitable tolling in more than 80 cases now pend-

ing before the PRRB, involving claims for more than 4000 cost reporting years.[13]

More than 35,000 institutional providers participate in the Medicare program, including more than 6100 hospitals, and each of those providers must file an annual cost report. See 42 C.F.R. 413.1(a)(2), 413.20(b), 413.24(f); see HHS, *2012 CMS Statistics* 21, 22 (June 2012) (*2012 Statistics*) (Tbls. II.3, II.5).[14] There is a very real potential for an equitable-tolling regime to seriously disrupt the Medicare provider payment process and take time and resources away from processing claims and appeals filed in compliance with the statutory and regulatory requirements, to the detriment of other Medicare providers. Cf. *Your Home*, 525 U.S. at 454 ("[T]he statutory purpose of imposing a 180-day limit * * * would be frustrated by permitting requests to reopen to be reviewed indefinitely."); *High Country*, 359 F.3d at 1311 ("The danger is that the deadline, which is supposed to help manage the burdens of a heavy caseload, will become a new (and less productive) font of litigation; instead of focusing on timely raised substantive claims, the adjudicator must expend resources on litigation about whether a party's excuse for missing the deadline was good enough."). That practical reality

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[13] HHS arrived at these figures based on the PRRB's search of its electronic database, decisions, and working files. The "approximately 450 providers" figure is an aggregate calculation; some providers may be involved in more than one of the pending appeals.

[14] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html (last visited Sept. 10, 2012).

reinforces the Secretary's judgment to adopt strict limitations on extending the appeal deadline.[15]

f. A judicially imposed equitable-tolling rule would also allow providers to circumvent the Secretary's limited reopening procedures that this Court sustained in *Your Home*. In that case, the Court held that reopening is discretionary when sought by the provider under 42 C.F.R. 405.1885 (1997), and that "[t]he right of a provider to seek reopening exists only by grace of the Secretary." *Your Home*, 525 U.S. at 454. The Court explained that, "given the administrative realities," it "would not be shocked by a system in which underpayments could *never* be the basis for reopening." *Id.* at 455. Indeed, the Court noted, "[t]he few dozen fiscal intermediaries often need three years within which to discover overpayments in the tens of thousands of NPRs that they issue, while each of the tens of thousands of sophisticated Medicare-provider recipients of these NPRs is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Id.* at 455-456.

An equitable-tolling rule would allow those "tens of thousands of sophisticated Medicare-provider recipients" to evade the carefully circumscribed limits in the reopening regulation. It would transform a provider's

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[15] Even if provider appeals to equity ultimately fall short in most cases, substantial resources would have to be devoted to adjudicating (before the Board) and litigating (in court) untimely claims. See *Credit Suisse Sec.*, 132 S. Ct. at 1419, 1421 (explaining that equitable tolling involves "fact-intensive disputes" about whether a litigant has diligently pursued his rights and whether "some extraordinary circumstances stood in his way") (citation omitted); *High Country*, 359 F.3d at 1311 ("[F]or every plaintiff whose substantive claim or reason for default leads an adjudicator to excuse the default, ten less sympathetic plaintiffs are likely to demand similar treatment.").

ability to seek reopening from a time-limited opportunity existing solely by grace of the Secretary into an open-ended regime fashioned by the courts using their own sense of what an equitable administrative process should look like. The same "administrative realities" that caused this Court in *Your Home* to envision a Medicare payment scheme without any opportunity for provider reopening, render such a judicially fashioned equitable-tolling regime contrary to the statutory and regulatory framework, as well as highly disruptive and burdensome. Cf. *Califano* v. *Sanders*, 430 U.S. 99, 108 (1977) ("limit[ing] judicial review to the original decision denying benefits is a policy choice obviously designed to forestall repetitive or belated litigation of stale eligibility claims").

2. In addition to imposing new and very burdensome procedures on HHS, in violation of *Vermont Yankee*, applying principles of equitable tolling to the 180-day administrative appeal deadline would effectively invalidate the Secretary's regulation allowing extensions only in narrow circumstances. That respondents do not formally challenge that regulation is of no consequence. Accepting their argument that the Board must consider untimely appeals invoking equitable tolling, regardless of when they are filed, would be tantamount to abolishing the Secretary's longstanding requirement that an appeal to the Board "shall be dismissed" if filed more than 180 days after the NPR, unless the provider shows "good cause" and requests an extension *no later than* three years after the NPR. Unless respondents can demonstrate that those limitations in the Secretary's regulation are "arbitrary, capricious, or manifestly contrary to the statute," that regulation must be sustained. *Chevron*, 467 U.S. at 843-844; see *Zebley*, 493

U.S. at 528; *Schreiber*, 381 U.S. at 291; *High Country*, 359 F.3d at 1313; see also 42 U.S.C. 1395*oo*(f)(1) (incorporating APA standards of review). For the reasons discussed in Part B, *infra*, the limitations in the good-cause regulation are not "manifestly contrary to the statute." And for the reasons set forth above, neither are they arbitrary and capricious.

Principles of finality and repose are critical to the administration of the Medicare program and to the Medicare Trust Fund. See *Palisades Gen. Hosp., Inc.* v. *Leavitt*, 426 F.3d 400, 404 (D.C. Cir. 2005); *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1232-1233 (D.C. Cir. 1994); see also 42 C.F.R. 405.1807. Absent fixed time limits, HHS and providers would have to stand ready to reassess and litigate any one of the hundreds of calculations that go into an annual determination of the amount due a provider for any given cost reporting period, and the Medicare Trust Fund would remain exposed to enormous and unpredictable liabilities that might be imposed many years (or even a decade or more) later. As HHS has explained, "[i]t is in the interest of providers and the program that, at some point, intermediary determinations and the resulting amount of program payment due the provider or the program become no longer open to correction." *PRM*, Pt. 1, § 2930, at 29-73.

Indeed, experience has caused the agency to expressly delineate and further narrow the limitations even on its own good-cause regulation. In 2004, the Secretary explained that "the case backlog at the Board * * * necessitate[d] revision" of the good-cause regulation because it added additional cases "to the backlog" and because the "lengthy 3-year period for requesting a good cause extension makes increases in the backlog more likely." 69 Fed. Reg. 35,725 (June 25, 2004); *id.* at

35,717 (noting backlog of approximately 10,000 cases); see 73 Fed. Reg. 30,205 (May 23, 2008); *id.* at 30,192 (noting backlog of approximately 6800 cases); see also *ibid.* (explaining that proposed amendments were designed to "lead to a more effective and efficient appeal process" and to reduce the "huge backlog of cases before the Board"). The Secretary "considered eliminating altogether any extensions of the 180-day period for requesting a hearing," but ultimately decided to retain the regulation while allowing untimely requests "only in extraordinary circumstances beyond [a provider's] control (for example, fire, catastrophe or strike) that existed prior to the expiration of the 180-day appeal period." *Id.* at 30,206. Again, the Secretary reiterated that three years is the absolute "outside limit" for extension requests, 73 Fed. Reg. at 30,206, and further specified that any such appeal must be filed "within a reasonable time (as determined by the Board under the circumstances) after the expiration of the 180-day limit," 42 C.F.R. 405.1836(b) (2011). See 42 C.F.R. 405.1836(c)(2) (2011). The Secretary's longstanding judgment—refined and strengthened based on practical experience—that the Board should not have authority to consider an untimely hearing request if the conditions specified in the good-cause regulation are not met cannot be said to be arbitrary or capricious.

B. Congress Did Not Intend To Subject The 180-Day Administrative Appeal Deadline To Equitable Tolling

Respondents nevertheless argue, and the court of appeals held, that the Medicare Act itself provides for equitable tolling of the 180-day administrative appeal deadline. They do not rely on the express terms of Section 1395*oo*(a)(3), which does not speak to equitable tolling or indeed mention any grounds for extending the

deadline. Nor do they rest on any other generally applicable tools of statutory interpretation. Instead, they rely heavily on a presumption in favor of the availability of equitable tolling. No such presumption applies here and, without a presumption, the statute is at best silent or ambiguous and the Secretary's considered judgment and reasonable regulations are controlling. See Part A, *supra*. But even if such a presumption applied in some form, it would be rebutted by the text, structure, and history of the statute, as well as its underlying subject matter and purpose.

1. In *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990), this Court considered whether the then-30 day time period for filing suit against a federal agency under Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e-16(c) (1988), was subject to equitable tolling. Seeking to reconcile its prior cases involving "the effect of time limits in suits against the Government," *Irwin*, 498 U.S. at 94, the Court started with the proposition that "[t]ime requirements in lawsuits between private litigants are customarily subject to 'equitable tolling,'" *id.* at 95. The Court acknowledged that statutory filing deadlines for suits against the government are conditions on Congress's waiver of sovereign immunity, and that waivers of sovereign immunity must be "unequivocally expressed." *Id.* at 94-95 (citation omitted). But the Court ultimately concluded that "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States." *Id.* at 95-96.

a. Before and after *Irwin*, the equitable-tolling cases before this Court have generally involved limitations periods for filing a suit in federal court. See, *e.g.*, *Holland* v. *Florida*, 130 S. Ct. 2549 (2010) (one-year

period for filing application for writ of habeas corpus); *Rotella* v. *Wood*, 528 U.S. 549 (2000) (four-year period for filing civil RICO suit); *United States* v. *Beggerly*, 524 U.S. 38 (1998) (12-year period to bring suit under Quiet Title Act); *Lampf, Pleva, Lipkind, Prupis & Petigrow* v. *Gilbertson*, 501 U.S. 350 (1991) (one- and three-year periods for commencing suit under Section 10(b) of the Securities Exchange Act of 1934); *Honda* v. *Clark*, 386 U.S. 484 (1967) (60-day period for filing suit under Trading with the Enemy Act); *Burnett* v. *New York Cent. R.R.*, 380 U.S. 424 (1965) (three-year period for filing suit under Federal Employers' Liability Act (FELA)); *Soriano* v. *United States*, 352 U.S. 270 (1957) (six-year period for filing suit in Court of Federal Claims); *Kendall* v. *United States*, 107 U.S. 123 (1883) (same). This Court has never applied the *Irwin* presumption to equitably toll a time limit governing the action of an administrative agency. The few cases that involved an administrative deadline are quite distinct from this case.

In *Zipes* v. *Trans World Airlines, Inc.*, 455 U.S. 385 (1982), the Court concluded that the statutory time limit for filing charges with the Equal Employment Opportunity Commission (EEOC) as a prerequisite to filing a suit under Title VII was not a "jurisdictional prerequisite to suit" in district court, but rather was subject to equitable doctrines such as waiver, estoppel, and tolling. *Id.* at 393. Although the case was about waiver and estoppel, not tolling, the Court concluded that permitting "waiver as well as tolling when equity so requires" would further "the remedial purpose" of Title VII "without negating the particular purpose of the filing requirement, to give prompt notice to the employer." *Id.* at 398. The Court further explained that applying

equitable principles was consistent with the statutory scheme, wherein "laymen, unassisted by trained lawyers, initiate the process." *Id.* at 397 (citation omitted); see *National R.R. Passenger Corp.* v. *Morgan*, 536 U.S. 101, 113 (2002).

In *Zipes*, the EEOC (and the United States) argued in favor of equitable modification of the charge-filing period. See U.S. Amici Br. at 10-21, *Zipes*, *supra* (Nos. 78-1545 and 80-951). And Title VII suits in federal court following EEOC proceedings are de novo actions. See *Chandler* v. *Roudebush*, 425 U.S. 840, 844, 864 (1976). In marked contrast, the considered judgment of the Secretary with respect to Medicare providers is that equitable tolling would be incompatible with the statutory and regulatory scheme. The task of applying equitable principles here would fall to an administrative tribunal expert "in the field of payment of providers of services," 42 U.S.C. 1395*oo*(h), and judicial review would proceed under the deferential standards of the APA, 42 U.S.C. 1395*oo*(f)(1). In addition, unlike the filing of charges under Title VII, the payment system under the Medicare Part A program applies to sophisticated providers which are often assisted by "trained lawyers."

United States v. *Brockamp*, 519 U.S. 347 (1997), involved the time period for filing a tax refund claim with the Internal Revenue Service (IRS). A tax refund suit, however, "is not an appellate review of the administrative decision that was made by IRS," but a de novo proceeding. *Wells Fargo & Co.* v. *United States*, 91 Fed. Cl. 35, 75 (2010) (citation omitted), aff'd, 641 F.3d 1319 (Fed. Cir. 2011); compare 42 U.S.C. 1395*oo*(f)(1) (applying APA standards). The Court in *Brockamp*, moreover, only "assume[d]," "for argument's sake," that the *Irwin* presumption applied, 519 U.S. at 350, and ultimately

held that tolling was unavailable. The Court's conclusion that the statutory text and structure, as well as the underlying subject matter and history, conclusively precluded equitable tolling was in full accord with the IRS's denial of the requested refunds as untimely. See U.S. Br. at 5, 10, *Brockamp*, *supra* (No. 95-1225).[16]

Respondents also rely (Br. in Opp. 19-20) on *Bowen* v. *City of New York*, 476 U.S. 467 (1986), but the Court there allowed equitable tolling of the 60-day limitations period for seeking *judicial* review of the Secretary's Social Security benefits determination. *Id.* at 478-482. The Court did discuss the administrative appeal deadline as well, but only in the section of the opinion addressing administrative exhaustion. *Id.* at 482-486. Moreover, even with respect to the 60-day period for filing a suit in court, the Court did not apply any presumption, but rather focused on whether equitable tolling was "consistent with Congress' intent." *Id.* at 479-480. Because the disability benefits scheme was "designed to be 'unusually protective' of claimants," *id.* at 480 (citation omitted), the Court concluded that equitable tolling was appropriate. The same cannot be said of the 180-day administrative appeal period for "sophisticated" institutional providers, *Your Home*, 525 U.S. at 456, to seek Medicare payment. The *City of New York* Court also observed that Congress had "authorized the Secretary to toll the 60-day limit, thus expressing its clear intention to allow tolling in some cases." 476 U.S.

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[16] *Young* v. *United States*, 535 U.S. 43 (2002), involved the "three-year lookback period" in the Bankruptcy Code. Although not involving a time limit for filing suit in court, that case does not directly inform how the Court should treat an administrative appeal deadline that the expert agency has determined should not be subject to equitable tolling.

at 480 (citing 42 U.S.C. 405(g) (1982)).[17] That indicium of congressional intent is absent here. See Amicus Br. 37-38; pp. 48-49, *infra* (addressing amicus argument).

b. Neither precedent nor logic suggests that the Court should mechanically apply the *Irwin* presumption to a statutory deadline governing an administrative appeal scheme of the sort at issue here. This Court has long recognized that there are functional differences between judicial and administrative tribunals, and that the failure to recognize those differences would cause courts to "read the laws of Congress through the distorting lenses of inapplicable legal doctrine." *Pottsville Broad.*, 309 U.S. at 144. The Court should heed that caution here.

The presumption of equitable tolling was adopted in part on the premise that "[s]uch a principle is likely to be a realistic assessment of legislative intent." *Irwin*, 498 U.S. at 95; see *John R. Sand & Gravel Co.* v. *United States*, 552 U.S. 130, 137 (2008) (purpose of rebuttable presumption is "to produce a set of statutory interpretations that will more accurately reflect Congress' likely meaning in the mine run of instances where it enacted a Government-related statute of limitations"). No such premise supports applying a presumption of equitable tolling in this case. Congress was concerned enough about finality to enact a statutory time deadline to

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[17] The Secretary exercised that delegated authority and issued regulations permitting extensions of time for good cause. See *City of N.Y.*, 476 U.S. at 480 n.12 (citing 20 C.F.R. 404.911, 416.1411 (1985)). Unlike the good-cause regulation governing appeals to the PRRB, see 42 C.F.R. 405.1841(b), the regulations at issue in *City of New York* imposed no outer time limit for seeking an extension and defined "good cause" broadly. In those circumstances, the Court concluded that the regulations additionally supported application of tolling principles. 476 U.S. at 480 n.12.

govern an appeal to the Board that does not on its face provide for extending the appeal time, whether based on equitable tolling or otherwise. See 42 U.S.C. 1395*oo*(a)(3). Rather, the Medicare Act confers on the Secretary extensive rulemaking and other authority with respect to the Board. Under established principles of administrative law, the Act thus delegates to the Secretary the authority to determine whether Section 1395*oo*(a)(3) may be construed to allow any extensions of the 180-day appeal period and, if so, whether and what sort of power should be conferred on the Board to allow extensions. Likewise under established principles of administrative law, the Secretary's interpretation and implementation of her authority under such statutory provisions after notice-and-comment rulemaking can be set aside only if arbitrary and capricious. See pp. 29-30, *supra*. It would be fundamentally inconsistent with these principles for the Court to nonetheless presume that Congress intended to *divest* the Secretary of her delegated authority and instead to confer authority on federal courts to impose equitable tolling. Indeed, the presumption should be precisely to the contrary, and neither the court of appeals nor respondents have pointed to any indication that Congress intended for courts to have that authority, rather than the Secretary.

The situation is the same as if Congress had enacted Section 1395*oo* in identical form, but without any time limit for filing an appeal with the Board, and the Secretary had adopted the very same regulations to govern Board proceedings. In that hypothetical, there would still be a 180-day appeal deadline (by regulation) and there would still be a limited opportunity to extend that deadline for good cause within three years. Under well-settled principles of administrative law, and under this

Court's equitable-tolling precedents, the "emphatic" regulatory time restrictions would not be subject to equitable tolling, cf. *Kontrick* v. *Ryan*, 540 U.S. 443, 458 (2004) (citation omitted)—especially where the responsible agency has construed the regulations to bar tolling, see *Thomas Jefferson*, 512 U.S. at 512. There is no reason for a different result here, where Section 1395*oo*(a)(3) is silent and the Secretary has been given authority to interpret and implement it.

2. The factors considered by this Court in cases discussing a presumption of equitable tolling also demonstrate that such a presumption is out of place here, or at the very least substantially weakened.

a. Although a "precise private analogue" to the particular type of suit against the government at issue is not required in order to invoke the *Irwin* presumption, *Scarborough* v. *Principi*, 541 U.S. 401, 422 (2004), the Court's reasoning in *Irwin* rested on the proposition that a rule in favor of equitable tolling should be "applicable to suits against the Government[] in the same way that it is applicable to private suits," 498 U.S. at 95. In *Brockamp*, the Court recognized the need to identify a private analogue, and assumed "only for argument's sake" that "a tax refund suit and a private suit for restitution" were sufficiently similar to warrant application of the *Irwin* presumption. 519 U.S. at 350. Unlike tort actions or employment disputes, however, claims for provider payment under the Medicare program are not comparable to any suit that can be brought against a private litigant. The court of appeals was of the view that a Medicare provider's administrative appeal seeking payment is sufficiently analogous to a private contract action, Pet. App. 6a n.1, but Medicare provider payments depend on the statute and the regulations, not

on independent contractual undertakings.[18] Respondents' claim that the Secretary should recalculate their Medicare payments under complex statutory and administrative standards is "so peculiarly governmental that there is no basis for assuming [that the] customary ground rules apply." *Chung* v. *United States Dep't of Justice*, 333 F.3d 273, 277 (D.C. Cir. 2003).

b. Moreover, a presumption in favor of equitable tolling, even if one applied at all, would be substantially weakened in this context. In *Holland*, this Court explained that the presumption of equitable tolling was "reinforced" and "strength[ened]" by two factors: (1) "the fact that equitable principles have traditionally governed the substantive law of habeas corpus," and (2) "the fact that Congress enacted [the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA)] after the Court decided *Irwin* and therefore was likely aware that courts, when interpreting AEDPA's timing provisions, would apply the presumption." 130 S. Ct. at 2560-2561 (internal quotation marks and citation omitted); *id.* at 2569 (Scalia, J., dissenting) (agreeing that the presumption is particularly strong when the underlying action is "traditionally governed by equitable principles"). Similarly, in *Young* v. *United States*, 535 U.S. 43 (2002), the Court noted that the *Irwin* presumption is appropriate "when [Congress] is enacting limitations periods to be applied by bankruptcy courts, which are courts of equity and apply the principles and rules of

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[18] The court of appeals suggested that *Holland* casts doubt on the need to search for a comparable private suit. Pet. App. 6a n.1. But in *Holland*, a state prisoner filed a habeas corpus petition against his custodian; it was not a suit against the United States, or one that implicated sovereign-immunity considerations.

equity jurisprudence." *Id.* at 50 (internal quotation marks, brackets, and citations omitted).

Neither factor is present here. First, unlike habeas corpus and bankruptcy litigation, and the Title VII discrimination claim presented in *Irwin*, general "equitable principles," unrooted in statutory or regulatory text, have not "traditionally governed" the "substantive law" of Medicare provider payment, let alone the administrative appeals process. Cf. *Brockamp*, 519 U.S. at 352 (noting that tax law "is not normally characterized by case-specific exceptions reflecting individualized equities"). Thus, the question here is not whether Congress has divested a court of its traditional equitable authority, *Holland*, 130 S. Ct. at 2560, but whether a court may impose on an administrative tribunal equitable powers that Congress and the Secretary declined to confer. See Pet. App. 55a-56a (holding that the Board has no residual equitable powers with respect to the 180-day deadline); see also pp. 17-29, *supra*. Second, the 180-day administrative appeal period was first enacted in 1972, 1972 SSA Amendments § 243(a), 86 Stat. 1420—18 years before this Court decided *Irwin*. Accordingly, Congress plainly was not "aware that courts, when interpreting" even federal statutes governing the filing of a suit against the United States in court, much less the Medicare Act's administrative-appeal "timing provisions, would apply the presumption." *Holland*, 130 S. Ct. at 2561.

3. In the end, the touchstone must be congressional intent. See *Brockamp*, 519 U.S. at 350 (whether there is "good reason to believe that Congress did *not* want the equitable-tolling doctrine to apply"); *City of N.Y.*, 476 U.S. at 480 (whether equitable tolling "is consistent with Congress' intent"); *Honda*, 386 U.S. at 501 (whether

equitable tolling is "[c]onsistent with the overall congressional purpose"); *Burnett*, 380 U.S. at 427 (whether equitable tolling "effectuates" the "congressional purpose"). Here, the statutory text, structure, and history, and the underlying subject matter and purpose, make clear that Congress "did not intend courts to read other unmentioned, open-ended 'equitable' exceptions into the statute that it wrote." *Brockamp*, 519 U.S. at 352. Any presumption in favor of equitable tolling therefore is rebutted.

The Court-appointed amicus curiae argues that many of the same indicia of congressional intent demonstrate that the statutory 180-day appeal period is an absolute limit on the Board's jurisdiction. See Part C, *infra*. Whether or not Section 1395*oo*(a)(3) standing alone is "jurisdictional" in that "strict sense of the term," *Hallstrom* v. *Tillamook County*, 493 U.S. 20, 31 (1989), the statute leaves no room for judicially imposed equitable tolling outside the controlling statutory and regulatory framework.

a. Section 1395*oo*(a) establishes several mandatory preconditions to obtaining a hearing before the PRRB. *First*, the appealing party must be a "provider of services" that "has filed a required cost report within the time specified in regulations," or a hospital that receives payments under the PPS and that "has submitted such reports within such time as the Secretary may require." 42 U.S.C. 1395*oo*(a). *Second*, the provider must either be "dissatisfied" with the final determination of the intermediary or the Secretary, or must not have received a final determination from the intermediary on a timely basis. 42 U.S.C. 1395*oo*(a)(1). *Third*, the amount in controversy must be $10,000 or more. 42 U.S.C. 1395*oo*(a)(2). *Fourth*, the provider must request a hear-

ing within 180 days after receiving notice of the intermediary's (or the Secretary's) final determination, or within 180 days after notice of the intermediary's determination should have been received if it had been made on a timely basis. 42 U.S.C. 1395*oo*(a)(3); see *1971 House Report* 108 ("The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination."). Nothing in the statutory text suggests that any of the preconditions to a Board hearing are amenable to judicially imposed equitable exceptions.

Although not as technical and repetitive as the time limit at issue in *Brockamp*, 519 U.S. at 350-352, the 180-day time limit is itself stated in absolute and unqualified terms. A provider is entitled to a hearing before the Board "*if*," among other things, it files a request within 180 days. 42 U.S.C. 1395*oo*(a)(3) (emphasis added). Unlike the judicial review deadline at issue in *City of New York*, Section 1395*oo* does not expressly provide for any exceptions to the 180-day deadline. See 476 U.S. at 476. "Under a literal reading of the statute, compliance with the" administrative appeal deadline is a "mandatory, not optional, condition precedent" to a hearing before the Board, and a "district court may not disregard" the deadline "at its discretion." *Hallstrom*, 493 U.S. at 26, 31.[19]

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[19] The statutory time limit also has substantive, as well as procedural, effects. See *Brockamp*, 519 U.S. at 352. Section 1395*oo*(f)(2) provides that, when a provider seeks judicial review, interest will accrue "beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section." 42 U.S.C. 1395*oo*(f)(2); see Amicus Br. 35 n.22. Tolling the 180-day deadline would seem to require a court to judicially alter the starting date for interest accrual—"a kind of tolling for which" there is "no direct precedent." *Brockamp*, 519 U.S. at 352.

The history of Section 1395*oo*(a)(3), as detailed above, reinforces the statutory text. Until 1972, the Medicare Act provided no avenue for providers to obtain administrative or judicial review. When Congress first directed the Secretary to establish the Board, it simultaneously imposed the 180-day deadline, with no express exceptions. For nearly forty years, the Secretary (through regulations, formal adjudications, and interpretive guidance) has prohibited the Board from extending that deadline, except as provided by regulation. And until the court of appeals' decision in this case, no court had ever superimposed extra-textual equitable tolling principles onto Section 1395*oo*(a)(3) and the Secretary's regulations implementing that provision. Against that backdrop, Congress amended Section 1395*oo* on numerous occasions and never expressed any disapproval of the Secretary's interpretation. See p. 20 & n.8, *supra*. "It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress." *Schor*, 478 U.S. at 846 (internal quotation marks and citation omitted). Accordingly, Congress may be understood to have acquiesced in the Secretary's interpretation. Cf. *John R. Sand & Gravel Co.*, 552 U.S. at 138-139 (requiring sua sponte consideration of timeliness where Congress had "long acquiesced" in the Court's interpretation of a statutory time deadline).

b. Section 1395*oo*(a)(3)'s underlying subject matter and purpose further confirm that equitable tolling is inconsistent with the statutory and regulatory scheme.

Section 1395*oo* is qualitatively different from the remedial statutes at issue in many of this Court's equitable-tolling cases. See *Irwin*, 498 U.S. at 91 (Title VII); *City of N.Y.*, 476 U.S. at 480 (Social Security disability benefits); *Zipes*, 455 U.S. at 398 (Title VII); *Honda*, 386 U.S. at 486, 495 (Trading with the Enemy Act); *Burnett*, 380 U.S. at 427 (FELA); cf. *Henderson* v. *Shinseki*, 131 S. Ct. 1197, 1204 (2011) (veterans disability benefits). The statutory scheme is not designed to be "'unusually protective' of claimants," *City of N.Y.*, 476 U.S. at 480 (citation omitted), nor is it one "in which laymen, unassisted by trained lawyers, initiate the process," *Zipes*, 455 U.S. at 397 (citation omitted). The payment system under Medicare Part A applies to "sophisticated" institutional providers that are assisted "by trained lawyers," and that are "generally capable of identifying an underpayment in [their] own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Your Home*, 525 U.S. at 455-456; see *Hallstrom*, 493 U.S. at 28.

The administrative appeal deadline also "relate[s] to an 'underlying subject matter[]' * * * with respect to which the practical consequences of permitting equitable tolling would [be] substantial." *Holland*, 130 S. Ct. at 2561 (quoting *Brockamp*, 519 U.S. at 352). In *Brockamp*, the Court concluded that "[t]he nature of the underlying subject matter" (tax collection) "underscore[d]" its conclusion that equitable-tolling principles could not be read into the statutory time limit. 519 U.S. at 352-353. In *Beggerly*, the Court held that the statutory time limit in the Quiet Title Act could not be equitably tolled because, among other things, "the underlying claim 'deal[t] with ownership of land' and thereby implicated landowners' need to 'know with certainty what their

rights are, and the period during which those rights may be subject to challenge.'" *Holland*, 130 S. Ct. at 2561 (brackets in original) (quoting *Beggerly*, 524 U.S. at 49). By contrast, the Court emphasized in *Holland* in allowing equitable tolling under AEPDA that, "unlike the subject matters at issue" in *Brockamp* and *Beggerly*, "AEDPA's subject matter, habeas corpus, pertains to an area of the law where equity finds a comfortable home." *Ibid.*; cf. *id.* at 2562 (considering whether equitable tolling would "undermine[]" the statute's "basic purposes").

Medicare Part A is far more analogous to the subject matter in *Brockamp* (tax collection) and *Beggerly* (land claims) than to the subject matter in *Holland* (habeas corpus) or *Irwin* (Title VII). The Medicare system is one of the most detailed and complex federal administrative programs ever created. See p. 18, *supra*. It is akin to tax collection in terms of its sheer size and complexity. Medicare contractors annually process millions of claims for more than 35,000 providers under Medicare Part A, see p. 27, *supra*, resulting in annual expenditures of more than $250 billion. *2012 Statistics* 29 (Tbl. III.5); cf. *Brockamp*, 519 U.S. at 352 ("The IRS processes more than 200 million tax returns each year" and "issues more than 90 million refunds."). More than $139 billion in Medicare Part A benefit payments are made annually for inpatient hospital services alone. *2012 Statistics* 30 (Tbl. III.6).

As explained in detail above (see Part A, *supra*), an equitable-tolling regime would place substantial administrative burdens on the agency, on its contractors, and on the Medicare Trust Fund that Congress did not envision and could not have intended. Thus, just as "read[ing] an 'equitable tolling' exception into [Section]

6511 [of the Internal Revenue Code] could create serious administrative problems by forcing the IRS to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for 'equitable tolling' which, upon close inspection, might turn out to lack sufficient equitable justification," *Brockamp*, 519 U.S. at 352, imposing equitable tolling on provider payment determinations under Medicare Part A would create similar administrative problems for HHS. And just as in *Brockamp*, "Congress would likely have wanted to decide explicitly"—or, as it did here, to delegate to the Secretary the authority to decide explicitly—"whether, or just where and when, to expand the statute's limitations periods, rather than delegate to the courts a generalized power to do so wherever a court concludes that equity so requires." *Id.* at 353. The result of imposing an equitable-tolling regime here would be to require a five-member administrative review body (the PRRB) created for its expertise in resolving technical hospital cost and payment issues to divine and apply judicially fashioned equitable-tolling principles far removed, both factually and legally, from the areas of its technical expertise. In the end, the "nature and potential magnitude of the administrative problem suggest that Congress decided to pay the price of occasional unfairness in individual cases * * * in order to maintain a more workable" payment system. *Id.* at 352-353; see *Taylor* v. *Freeland & Kronz*, 503 U.S. 638, 644 (1992) ("Deadlines may lead to unwelcome results, but they prompt parties to act and they produce finality."); *Your Home*, 525 U.S. at 455 (noting that the Court "would not be shocked by a system in which [Medicare] underpayments could *never* be the basis for reopening").

C. The 180-Day Administrative Appeal Deadline Is Not "Jurisdictional" In The Strictest Sense Of That Term

The Court-appointed amicus curiae argues that Section 1395*oo*(a)(3)'s timely filing requirement is "jurisdictional" because the 180-day appeal deadline limits the Board's adjudicatory authority. Amicus is correct to a point. The Board has no authority to adjudicate any appeal filed more than 180 days after the NPR—except as provided by regulation. Section 1395*oo*(a)(3) limits the Board's jurisdiction; it does not preclude the Secretary from adopting a narrow and time-limited good-cause regulation in the exercise of her broad authority under the Medicare Act. If the good-cause regulation did not exist, however, the Secretary agrees that any hearing request filed more than 180 days after the NPR would be jurisdictionally barred.

1. The 180-day filing deadline is a critical limitation on a provider's ability to obtain a hearing before the Board. It is therefore reasonable for amicus to characterize that time limit as "jurisdictional" in the sense that it constrains the Board's adjudicative powers. The Secretary, however, has authority to interpret and implement Section 1395*oo*. The Secretary has permissibly interpreted Section 1395*oo*(a)(3) to permit her to extend the time limit in certain circumstances, and the good-cause regulation is a proper exercise of that authority. As a result, Section 1395*oo*(a)(3) and the regulations implementing it *together* establish the time limits on the Board's adjudicative powers.

Nothing in the statutory text or history suggests that Congress intended to prohibit the Secretary from implementing Section 1395*oo*(a)(3) in this manner. The Medicare Act directed the Secretary to "establish[]" the Board, 42 U.S.C. 1395*oo*(a), and the scope of the Board's

adjudicatory authority is set forth in that same section. Shortly before Congress enacted Section 1395*oo*(a)(3), the Secretary promulgated regulations affording providers a right to administrative review, *i.e.*, an intermediary hearing, that included a virtually identical good-cause exception. See 37 Fed. Reg. at 10,724. And in implementing regulations promulgated immediately after Congress created a new avenue of administrative review through a Board hearing, the Secretary adopted a parallel good-cause regulation to govern those proceedings. See 39 Fed. Reg. at 34,517; *id.* at 34,516 (retaining good-cause exception for intermediary hearings); *Schor*, 478 U.S. at 844 (agency's "contemporaneous interpretation of the statute it is entrusted to administer" is entitled to "considerable weight"). The good-cause regulation remained unchanged for more than thirty years, until it was narrowed further in 2008. See 73 Fed. Reg. at 30,205-30,207. Congress has never altered the Secretary's rulemaking authority or questioned her implementation of Section 1395*oo*(a)(3). See *Schor*, 478 U.S. at 845-846; pp. 20, 43, *supra*.

Amicus points to (Br. 36-37) provisions governing administrative and judicial review for Medicare beneficiaries and contrasts them with 42 U.S.C. 1395*oo*(a)(3), which governs review for Medicare providers. Amicus notes that those provisions were enacted (for Medicare providers) or amended (for Medicare beneficiaries) by Congress in 1972, but only the latter "gave the Secretary explicit discretion over the time requirements." Br. 36. As amicus acknowledges (Br. 36 n.25), however, Congress first adopted the provisions governing Medicare *beneficiary* appeals at the inception of the Medicare program in 1965. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869, 79 Stat. 330. In doing

so, Congress simply incorporated the preexisting procedures governing Social Security benefit claims. *Ibid.* While it is true that the incorporated procedures explicitly afforded the Secretary discretion to adopt certain time requirements to govern both judicial and administrative review, those provisions were enacted in 1939 and 1956, respectively. See Social Security Act Amendments of 1939, ch. 666, § 205(g), 53 Stat. 1370; Social Security Act Amendments of 1956, ch. 836, § 111, 70 Stat. 831. The 1972 amendments to the Medicare Act did not alter those incorporated provisions. See 1972 SSA Amendments § 299O, 86 Stat. 1464. Thus, Congress expressly gave the Secretary authority to adopt time limits (or allow an extension of statutory time limits) governing the review process for another government program decades before establishing Medicare; incorporated those provisions into the Medicare Act to govern beneficiary appeals at a time when the statute afforded providers no review; and amended that provision as part of the 1972 amendments that also directed the Secretary to establish the Board. That is too thin a reed on which to base an inference that Congress's silence in Section 1395*oo*(a)(3) was intended to prevent the Secretary, exercising her otherwise broad authority to administer the Medicare program, from allowing limited extension of the appeal deadline for "good cause" shown.

2. That the Secretary's good-cause regulation concerns the Board's adjudicatory jurisdiction does not diminish the deference that it is due. "[I]t is settled law that the rule of deference applies even to an agency's interpretation of its own statutory authority or jurisdiction." *Mississippi Power & Light Co.* v. *Mississippi ex rel. Moore*, 487 U.S. 354, 381 (1988) (Scalia, J., concur-

ring in the judgment) (citing cases); accord *Schor*, 478 U.S. at 845 (substantial deference due to regulation defining scope of agency jurisdiction); *NLRB* v. *City Disposal Sys., Inc.*, 465 U.S. 822, 830 n.7 (1984). And, in *Your Home*, this Court recognized the Secretary's authority to determine the bounds of the Board's jurisdiction. See 525 U.S. at 453 (deferring to Secretary's interpretation that a "final determination" subject to review by the Board under Section 1395*oo*(a)(1)(A)(i) did not include an intermediary's refusal to reopen a prior determination); cf. *Salfi*, 422 U.S. at 764, 766-767 (holding that Secretary had authority to "determin[e] in particular cases that full exhaustion of internal review procedures is not necessary for a decision to be [a] 'final' [decision] within the language of [Section] 405(g)," a requirement "central to the requisite grant of subject-matter jurisdiction").

Indeed, the regulations providing for reopening of closed payment determinations—a procedure not provided for in the Medicare Act at all, see *Your Home*, 525 U.S. at 454—are a prime example of the Secretary's authority to confer (and divest) the Board of jurisdiction over particular appeals. See 42 C.F.R. 405.1885(a). In *Your Home*, the Court deferred to the Secretary and held that the Board lacks jurisdiction to review a fiscal intermediary's refusal to reopen a final determination. The parties disputed whether the Secretary had clearly divested the Board of jurisdiction, but the Court found the answer to that question immaterial because the provider "would still have to establish that the Board's appellate jurisdiction is somewhere *conferred*." 525 U.S. at 453. To answer that question, the Court looked first to the Secretary's regulations, and second to the Medicare Act. *Ibid.* One regulation, the Court explained,

granted the Board jurisdiction over an "intermediary's affirmative decision to reopen and revise" a final determination, but it said "nothing about appeal of a refusal to reopen." *Ibid.* (citing 42 C.F.R. 405.1889 (1999)). Implicit in the Court's reasoning is the understanding that the regulations *could* have conferred jurisdiction on the Board to review an intermediary's refusal to reopen. If the Secretary could amend the reopening regulations to grant providers a right to an administrative appeal in those circumstances (*i.e.*, to challenge an intermediary's refusal to reopen after expiration of the 180-day period for requesting a Board hearing), it is difficult to understand why the Secretary cannot afford providers a limited opportunity to seek an extension of the 180-day appeal deadline from the Board directly.

To be sure, the Secretary's discretion to construe and implement the jurisdictional requirements in Section 1395*oo*(a), including the 180-day time limit, is not boundless. Cf. *United States* v. *Locke*, 471 U.S. 84, 102 n.14 (1985) (noting, without deciding, that an agency may have been "well within its authority to promulgate regulations construing" a "December 30" deadline as allowing "December 31 filings"). But the Secretary's carefully circumscribed and rarely applied good-cause regulation hardly upsets Congress's clear intent to limit the Board's authority to timely filed claims.

3. Amicus contends (Br. 42-47) that HHS has not adopted a consistent position on the jurisdictional status of Section 1395*oo*(a)(3). But as this Court has recognized, the word "jurisdiction" has often been used to convey "many, too many, meanings." *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 90 (1998) (citation omitted). Properly understood, the good-cause regula-

tion is entirely consistent with HHS's statements regarding the jurisdictional nature of Section 1395*oo*(a)(3).

As amicus explains (Br. 43-44), the Board's general practice (evidenced by this case, Pet. App. 55a) is to dismiss untimely requests for a hearing, or requests that fail to satisfy other Section 1395*oo*(a) prerequisites, for want of "jurisdiction." Similarly, the Administrator's practice is to affirm such "jurisdictional" dismissals or to vacate in cases where the Board lacked "jurisdiction." When relevant, however, both the Board and the Administrator have explained that the Board's adjudicative authority (*i.e.*, its "jurisdiction") is defined by Section 1395*oo*(a) *and* by the Secretary's regulations. In this case, for example, the Board explained that its adjudicatory authority is limited to the "powers granted to it by statute and regulation." Pet. App. 55a; see also, *e.g.*, *Medical Coll. of Ga. Hosp.*, 2010 WL 4214222, at *3 (PRRB); *SKI Group*, 2009 WL 981317, at *4 (PRRB); *QRS 96 DSH MediKan Days Grp.*, 2007 WL 1804053, at *5 & n.9 (CMS Adm'r May 25, 2007); *Sacred Heart Med. Ctr.*, 1998 WL 1064771, at *2 & n.5 (HCFA Adm'r Dec. 21, 1998).[20]

Amicus also relies (Br. 45) on the 2008 amendments to the regulations that now refer specifically to the timely filing requirement under the heading "Board

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[20] The Board has, at times, cited to *Alacare Home Health Services* v. *Sullivan*, 891 F.2d 850, 855-856 (11th Cir. 1990), and *St. Joseph's Hospital* v. *Heckler*, 786 F.2d 848, 852-853 (8th Cir. 1986), when denominating the Section 1395*oo*(a)(3) requirement as "jurisdictional." *E.g.*, *SKI Group*, 2009 WL 981317, at *5-*6 & n.11 (citing decisions favorably but noting that the courts had held the Secretary's good-cause regulation invalid). Both cases held that Section 1395*oo*(a)(3) is "jurisdictional" in nature and admits of no exceptions, and on that basis declared invalid the Secretary's regulation permitting extension of the 180-day period for "good cause."

jurisdiction." See 42 C.F.R. 405.1840(a)(2) (2011); cf. 42 C.F.R. 405.1873 (pre-2008 regulation addressing "Board jurisdiction" without specific mention of 180-day filing deadline). That regulation provides that "[t]he Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy has been met)." 42 C.F.R. 405.1840(a)(2) (2011). But the parenthetical's reference to whether a request for a hearing was "timely" obviously encompasses the provision elsewhere in the regulations governing Board hearings that permit an extension beyond 180 days in narrow circumstances.[21]

* * * * *

In the end, however, the Secretary and the Court-appointed amicus agree on the most fundamental point: the 180-day administrative appeal deadline is not subject to judicially imposed equitable tolling, and the court of appeals' decision should be reversed.

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[21] The same parenthetical is included in 42 C.F.R. 405.1814 (2011), which requires an "intermediary hearing officer[]" to make a similar determination as to "its jurisdiction." 73 Fed. Reg. at 30,207 (explaining that the parenthetical was added to both sections to add "clarity"). That is significant because an intermediary hearing officer's "jurisdiction" is entirely the product of regulation, not statute. Referring to the Board's "jurisdiction" in the same terms as the intermediary hearing officer's "jurisdiction" is consistent with HHS's understanding of its authority.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX A

1. 42 U.S.C. 405(a) provides:

Evidence, procedure, and certification for payments

(a) Rules and regulations; procedures

The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

2. 42 U.S.C. 405(g) provides in pertinent part:

Evidence, procedure, and certification for payments

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. * * *

3. 42 U.S.C. 1302(a) provides:

Rules and regulations; impact analyses of Medicare and Medicaid rules and regulations on small rural hospitals

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

4. 42 U.S.C. 1395x(v)(1)(A) provides:

Definitions

For purposes of this subchapter—

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the

amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

5. 42 U.S.C. 1395hh(a)(1) provides:

Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

6. 42 U.S.C. 1395ii provides:

Application of certain provisions of subchapter II

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and *(l)* of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

7. 42 U.S.C. 1395*oo* provides:

Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secre-

tary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

8. 42 U.S.C. 1395ww(d)(5) provides in pertinent part:

Payments to hospitals for inpatient hospital services

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

* * * * *

(F)(i) For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

* * * * *

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a

disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to

supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

* * * * *

9. 20 C.F.R. 405.492(a) (1973) provides:

Right to hearing on a notice of program reimbursement determination.

(a) A provider who has been furnished a notice of amount of program reimbursement may request an intermediary hearing if (1) he is dissatisfied with the intermediary's determination contained in such notice and (2) the amount of program reimbursement in issue is $1,000 or more. Such request must be in writing and be filed with the intermediary within 60 calendar days after the date of the notice of program reimbursement.

10. 20 C.F.R. 405.493 (1973) provides:

Failure to timely request a hearing on a notice of program reimbursement determination.

Where a provider requests a hearing on a notice of amount of program reimbursement determination after the time limit prescribed in § 405.492(a), the designated individual(s) of the intermediary responsible for the hearing procedure shall dismiss the request and furnish the provider a written notice which explains the time limitation, except that for good cause shown the time limit prescribed in § 405.492(a) may be extended. However, no such extension shall be granted if such request is filed more than 3 years after the date of the notice of program reimbursement.

11. 42 C.F.R. 405.1801(b)(1) (2007) provides:

Introduction.

* * * * *

(b) *General rule—(1) Providers.* The principles of reimbursement for determining reasonable cost and prospective payment are contained in parts 413 and 412, respectively, of this chapter. In order to be reimbursed for covered services furnished to Medicare beneficiaries, providers of services are obliged to file cost reports with their intermediaries as specified in § 413.24(f) of this chapter. Where the term "provider" appears in this subpart, it includes hospitals paid under the prospective payment system for purposes of applying the appeal procedures described in this subpart to those hospitals.

12. 42 C.F.R. 405.1803 (2007) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the ba-

sis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

(2) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (see part 412 of this chapter), the intermediary must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by the hospital during the cost reporting period covered by the notice.

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, CMS Rulings, or program instructions to explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

(c) *Use of notice as basis for recoupment of overpayments.* The intermediary's determination contained in its notice is the basis for making the retroactive adjustment (required by § 413.64(f) of this chapter) to any program payments made to the provider during the period to which the determination applies, including re-

coupment under § 405.373 from ongoing payments to the provider of any overpayments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

13. 42 C.F.R. 405.1805 (2007) provides:

Parties to intermediary determination.

The parties to the intermediary's determination are the provider and any other entity found by the intermediary to be a related organization of the provider under § 413.17 of this chapter.

14. 42 C.F.R. 405.1813 (2007) provides:

Failure to timely request an intermediary hearing.

If a provider requests an intermediary hearing on an intermediary's determination after the time limit prescribed in § 405.1811, the designated intermediary hearing officer or panel of hearing officers will dismiss the request and furnish the provider a written notice that explains the time limitation, except that for good cause shown, the time limit prescribed in § 405.1811 may be extended. However, an extension may not be granted if the extension request is filed more than 3 years after the date of the original notice of the intermediary determination.

15. 42 C.F.R. 405.1835 (2007) provides:

Right to Board hearing.

(a) *Criteria.* The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:

(1) An intermediary determination has been made with respect to the provider; and

(2) The provider has filed a written request for a hearing before the Board under the provisions described in § 405.1841(a)(1); and

(3) The amount in controversy (as determined in § 405.1839(a)) is $10,000 or more.

(b) *Prospective payment exceptions.* Except with respect to matters for which administrative or judicial review is not permitted as specified in § 405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.

(c) *Right to hearing based on late intermediary determination about reasonable cost.* Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary's determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report (as permitted or as required to furnish sufficient data for purposes of making such determination—

see § 405.1803(a)) provided such delay was not occasioned by the fault of the provider.

16. 42 C.F.R. 405.1836 (2011) provides:

Good cause extension of time limit for requesting a Board hearing.

(a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

(b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

(c) The Board may not grant a request for an extension under this section if—

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the Board must give prompt written notice to the provider, and mail a copy of the notice to each party to the appeal. The notice must include a detailed explanation of the reasons for the decision by the Board and the facts underlying the decision.

(e)(1) If the Board denies an extension request and determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Board dismissal decision dismissing the appeal for lack of Board jurisdiction. This decision by the Board must be in writing and include the explanation of the extension request denial required under paragraph (d) of this section, in addition to specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal (as described in § 405.1840(c) of this subpart). A copy of the Board's dismissal decision must be mailed promptly to each party to the appeal (as described in § 405.1843 of this subpart).

(2) A Board dismissal decision under paragraph (e)(1) of this section is final and binding on the parties, unless the decision is reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) This Board decision is inoperative during the 60-day period for review of the decision by the Administra-

tor, or in the event the Administrator reverses, affirms, modifies, or remands that decision, within the period.

(ii) A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened and revised by the Board in accordance with § 405.1885 through § 405.1889 of this subpart.

(3) The Administrator may review a Board decision granting an extension request solely during the course of an Administrator review of one of the Board decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2) of this subpart.

(4) A finding by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time for requesting a Board hearing is not subject to judicial review.

17. 42 C.F.R. 405.1837 (2007) provides:

Group appeal.

(a) *Criteria for group appeals.* Subject to paragraph (b) of this section, a group of providers may bring an appeal before the Board but only if—

(1) Each provider in the group is identified as one which would, upon the filing of a request for a hearing before the Board, but without regard to the $10,000 amount in controversy requirement, be entitled to a hearing under § 405.1835;

(2) The matters at issue involve a common question of fact or of interpretation of law, regulations or CMS Rulings; and

(3) The amount in controversy is, in the aggregate, $50,000 or more.

(b) *Providers under common ownership or control.* Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the aggregate, $50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.

18. 42 C.F.R. 405.1839 (2007) provides:

Amount in controversy.

(a) *Single appeals.* The $1,000 amount in controversy required under § 405.1809 for an intermediary hearing and the $10,000 amount in controversy required under § 405.1835 for a Board hearing is, as applicable to the matters for which the provider has requested a hearing, the combined total of the amounts computed as follows:

(1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—

(i) The total of the payment due the provider on other than a reasonable cost basis under the prospective

payment system from the total amount that would be payable after a recomputation that takes into account any exclusion, exception, adjustment, or additional payment denied the provider under part 412 of this chapter, as applicable;

(ii) The total of the payment due the provider on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed by the provider; and

(iii) The adjusted total reimbursable costs due the provider on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed by the provider.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider.

(b) *Group appeals.* The $50,000 amount in controversy required under § 405.1837 for group appeals to the Board is, as applicable to the common matters for which the group of providers have requested a hearing, the combined total of the amounts computed as follows:

(1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—

(i) The total of the payment due the providers (in the aggregate) on other than a reasonable cost basis under the prospective payment system from the total amount that would be payable to the providers (in the aggregate) after a recomputation that takes into account

any applicable exception, exclusion, adjustment, or additional payment denied the providers under part 412 of this chapter.

(ii) The total of the payment due the providers (in the aggregate) on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers; and

(iii) The adjusted total reimbursable costs due the providers (in the aggregate) on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the providers (in the aggregate) on a reasonable cost basis from the total reimbursable costs claimed in the aggregate by the providers.

19. 42 C.F.R. 405.1841 (2007) provides:

Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the pro-

vider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see § 413.17 of this chapter) must be brought by the providers as a group appeal (see § 405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or CMS Rulings common to the providers and for which the amount in controversy is $50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

20. 42 C.F.R. 405.1843 (2007) provides:

Parties to Board hearing.

(a) The parties to the Board hearing shall be the provider, the intermediary (including the Centers for Medicare & Medicaid Services when acting directly as intermediary) that rendered the determination being appealed (see § 405.1833), and any other entity found by the intermediary to be a related organization of such provider.

(b) Except as provided in paragraph (a), neither the Secretary nor the Centers for Medicare & Medicaid Services may be made a party to the hearing. However, the Board may call as a witness any employee or officer of the Department of Health and Human Services having personal knowledge of the facts and the issues in controversy in a hearing pending before the Board and may call as a consultant to the Board in connection with any such hearing any individual designated by the Secretary for such purpose. (See § 405.1863.)

21. 42 C.F.R. 405.1867 (2007) provides:

Sources of Board's authority.

In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator of the Centers for Medicare & Medicaid Services (see § 401.108 of this subchapter). The Board shall afford great weight to interpretive rules, general statements of policy, and rules

of agency organization, procedure, or practice established by CMS.

22. 42 C.F.R. 405.1869 (2007) provides:

Scope of Board's decisionmaking authority.

The Board shall have the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and to make any other modifications on matters covered by such cost report (including modifications adverse to the provider or other parties) even though such matters were not considered in the intermediary's determination. The opinion of the majority of those Board members deciding the case will constitute the Board's decision.

23. 42 C.F.R. 405.1873 (2007) provides:

Board's jurisdiction.

(a) *Board decides jurisdiction.* The Board decides questions relating to its jurisdiction to grant a hearing, including (1) the timeliness of an intermediary determination (see § 405.1835(c)), and (2) the right of a provider to a hearing before the Board when the amount in controversy is in issue (see §§ 405.1835(a)(3) and 405.1837).

(b) *Matters not subject to board review.* (1) The determination of a fiscal intermediary that no payment may be made under title XVIII of the Act for any expenses incurred for items and services furnished to an individual because such items and services are excluded from coverage pursuant to section 1862 of the Act, 42 U.S.C. 1395y (see subpart C of this part), may not be reviewed by the Board. (Such determination shall be re-

viewed only in accordance with the applicable provisions of subpart G or H of this part.)

(2) The Board may not review certain matters affecting payments to hospitals under the prospective payment system as provided in § 405.1804.

24. 42 C.F.R. 405.1885 (2007) provides:

Reopening a determination or decision.

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

(b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3-year period specified in paragraph (a) of this section, CMS—

(i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and

(ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.

(2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

(3) Notwithstanding paragraph (b)(1)(i) of this section, CMS may direct the intermediary to reopen a particular intermediary determination or intermediary hearing decision in order to implement, for the same intermediary determination or intermediary decision—

(i) A final agency decision under §§ 405.1833, 405.1871(b), 405.1875, or 405.1877(a) of this part;

(ii) A final nonappealable court judgment; or

(iii) An agreement to settle an administrative appeal or a lawsuit.

(c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.

(e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

(f) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c).) However, the 3-year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27, 1972 (the effective date of regulations which, prior to the publication of this Subpart R, governed the reopening of such determinations).

25. 42 C.F.R. 412.106(b) (2007) provides:

Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) *Determination of a hospital's disproportionate patient percentage—(1) General rule.* A hospital's dis-

proportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (or Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (or Medicare Advantage (Part C)).

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a per-

centage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

* * * * *

APPENDIX B[1]

1. *St. Joseph Med. Ctr.* v. *Sebelius*, No. 11-1381 (D.D.C. filed July 27, 2011) (2 providers; 18 cost reporting years (1987-1995)). The case has been stayed pending the outcome of this case. See 5/3/12 Minute Order.[2]

2. *Deaconess Med. Ctr.* v. *Sebelius*, No. 11-1335 (D.D.C. filed July 20, 2011) (2 providers; 13 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/3/12 Minute Order.

3. *Carrolton Home Care, Inc.* v. *Sebelius*, No. 10-1697 (D.D.C. filed Oct. 5, 2010) (4 providers; 5 cost reporting years (2006-2008)). The case has been stayed for reasons unrelated to this case. See 4/6/11 Minute Order.[3]

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[1] HHS provided this Office with a list of civil actions by providers challenging the PRRB's refusal to excuse their untimely administrative appeals. Those cases are summarized in this appendix. Each item contains the number of providers and the number of cost reporting years at issue in the case. The number of cost reporting years captures every appeal by a provider for the fiscal years in question. All information in this appendix can be found in documents available at Public Access to Court Electronic Records (PACER).

[2] The cases listed in items 1-2, 5, 7, 9-19 involve suits by providers relying on *Baystate* and invoking equitable tolling to seek recalculation of payment determinations.

[3] The cases listed in items 3-4, 6, and 8 involve challenges by hospice providers to repayment demands that invoke equitable tolling to excuse untimely administrative appeals. With the exception of item 6, all of these cases involve both timely and untimely appeals. The entries in this appendix capture only cost reporting years for the untimely appeals.

4. *Russell-Murray Hospice, Inc.* v. *Sebelius*, No. 10-5326 (D.C. Cir. filed Sept. 30, 2010) (1 provider; 1 cost reporting year (2006)). The appeal has been held in abeyance pending the outcome of this case. See 6/25/12 Clerk's Order.

5. *Bon Secours Health Sys., Inc.* v. *Sebelius*, No. 10-1406 (D.D.C. filed Aug. 20, 2010) (10 providers; 80 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 11/3/10 Order.

6. *Heaven & Earth Hospice, LLC* v. *Sebelius*, No. 10-1166 (D.D.C. filed July 12, 2010) (1 provider; 2 cost reporting years (2006-2007)). The case has been stayed pending the outcome of this case. See 8/29/12 Minute Order.

7. *Forsyth Med. Ctr.* v. *Sebelius*, No. 10-1038 (D.D.C. filed June 17, 2010) (3 providers; 30 cost reporting years (1987-1996)). The case has been stayed pending the outcome of this case. See 8/27/10 Minute Order.

8. *Hospice Advantage* v. *Sebelius*, No. 10-845 (D.D.C. filed May 21, 2010) (1 provider; 1 cost reporting year (2007)). The case has been stayed for reasons unrelated to this case. See 4/6/11 Minute Order.

9. *Alameda County Med. Ctr.* v. *Sebelius*, No. 09-1465 (D.D.C. filed Aug. 4, 2009) (29 providers; approximately 500 cost reporting years (1986-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

10. *Fremont Med. Ctr.* v. *Sebelius*, No. 09-1449 (D.D.C. filed July 31, 2009) (2 providers; 20 cost reporting years (1986-1993, 1996, 1998-1999)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

11. *Haw. Pac. Health* v. *Sebelius*, No. 09-1448 (D.D.C. filed July 31, 2009) (2 providers; 30 cost reporting years (1986-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

12. *Alta Bates Med. Ctr.* v. *Sebelius*, No. 09-1447 (D.D.C. filed July 31, 2009) (25 providers; approximately 300 cost reporting years (1986-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

13. *Daughters of Charity Health Sys.* v. *Sebelius*, No. 09-1446 (D.D.C. filed July 31, 2009) (5 providers; 48 cost reporting years (1986-1993, 2000-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

14. *Regents of Univ. of Cal.* v. *Sebelius*, No. 09-1445 (D.D.C. filed July 31, 2009) (6 providers, 60 cost reporting years (1986-2000)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

15. *Casa Grande Cmty. Hosp.* v. *Sebelius*, No. 09-1443 (D.D.C. filed July 31, 2009) (21 providers; approximately 168 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

16. *Arroyo Grande Cmty. Hosp.* v. *Sebelius*, No. 09-1441 (D.D.C. filed July 31, 2009) (42 providers; approximately 580 cost reporting years (1986-2005)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

17. *Columbia Hosp.* v. *Sebelius*, No. 09-1093 (D.D.C. filed June 15, 2009) (21 providers; approximately 168 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

18. *Valley Presbyterian Hosp.* v. *Sebelius*, No. 09-1034 (D.D.C. filed June 3, 2009) (1 provider; 11 cost reporting years (1987-1997)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

19. *Aurora Sinai Med. Ctr.* v. *Sebelius*, No. 09-823 (D.D.C. filed May 5, 2009) (14 providers; approximately 112 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

RESPONDENT'S BRIEF

Supreme Court, U.S.
FILED
OCT 16 2012
OFFICE OF THE CLERK

No. 11-1231

IN THE

Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, *ET AL.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTIONS PRESENTED

I. Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. § 1395*oo*(a)(3), may be extended for any reason.

II. Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. § 1395*oo*(a)(3), is subject to equitable tolling.

PARTIES TO THE PROCEEDING

Petitioner, appellee below, is Kathleen Sebelius, Secretary, United States Department of Health and Human Services.

Respondents, appellants below, are Auburn Regional Medical Center, Chalmette Regional Medical Center, Doctors' Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, McAllen Medical Center, Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital, UHS of New Orleans, Universal Health Services, Inc., Valley Hospital Medical Center, and Wellington Regional Medical Center.

CORPORATE DISCLOSURE STATEMENT

There are no changes to the disclosure statement included in the brief in opposition in this case.

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In The
Supreme Court of the United States

No. 11-1231

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, *ET AL.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENTS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-10a) is reported at 642 F.3d 1145. The order and opinion on denial of rehearing en banc (Pet. App. 63a-66a) are reported at 685 F.3d 1059. The district court's opinion (Pet. App. 11a-50a) is reported at 686 F. Supp. 2d 55. The Secretary's decision declining to review the decisions of the Provider Reimbursement Review Board (Pet. App. 57a-58a), and the decisions of the Board (Pet. App., *e.g.*, 51a-56a), are unreported.

JURISDICTION

The court of appeals entered its judgment on June 24, 2011. Pet. App. 1a. The Secretary's petition for rehearing and for rehearing en banc was denied on December 20, 2011. Pet. App. 61a-66a. The Chief Justice extended the time within which to file a petition for a writ of certiorari to and including April 13, 2012, and the petition was timely filed on that date. Certiorari was granted on June 25, 2012. This Court has jurisdiction under 28 U.S.C. § 1254(1).

RELEVANT STATUTORY AND REGULATORY PROVISIONS

The relevant statutory and regulatory provisions are set forth in the appendix to this brief.

STATEMENT

Medicare is a federal health insurance program established in 1965 to ensure that elderly and disabled individuals have access to high-quality medical care in their local communities. *See* Social Security Act, Title XVIII, 42 U.S.C. §§ 1395 *et seq.* Part A of the Act authorizes the Secretary to enter into agreements with hospitals and other medical providers to furnish services to Medicare beneficiaries. 42 U.S.C. § 1395cc. The Secretary must reimburse those providers consistently with the governing statute for the costs incurred in treating Medicare patients. *See* 42 U.S.C. §§ 1395d, 1395f. Thousands of hospitals—including hundreds of hospitals owned by State and local governments, as well as non-profit organizations—provide these critical Medicare services. Nearly two-thirds of the hospitals that furnish services to Medicare beneficiaries are not-for-profit hospitals.

Respondents, eighteen not-for-profit and for-profit health care providers ("Hospitals"), entered into agreements with the Secretary to provide needed Medicare services and to be compensated for those services as provided by law. In 2006, the Hospitals learned for the first time that the Secretary had substantially underpaid them for services rendered from 1987 to 1994 as the result of the Secretary's knowing, system-wide miscalculations involving information within the agency's exclusive knowledge and control. *See Baystate Med. Ctr.*, PRRB Dec. No. 2006-D20, 2006 WL 752453, at *33 (Mar. 17, 2006). The Secretary had refused for years to disclose both the relevant data and its knowledge of its own systemic mispayments. *See id.* at *3, *27 (describing agency's failure to comply with subpoenas or to release information); 61 Fed. Reg. 46,166, 46,206 (Aug. 30, 1996) (hospitals could not access the underlying data). The agency's pervading miscalculations and departure from announced policy and practice became public only after the procedural window for the Hospitals to contest the payments had closed. Pet. App. 2a.

The question in this case is whether, when the agency knowingly and systematically underpays providers through the concealed misuse of information within its sole and exclusive knowledge and control, Congress foreclosed those hospitals that provide critical safety-net services to vulnerable Medicare patients from seeking the statutorily authorized compensation due to them after that agency misfeasance is later uncovered.

A. Statutory And Regulatory Framework

1. As relevant here, Part A of the Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, establishes a federally funded health insurance program that covers inpatient services furnished to elderly and disabled beneficiaries. *See* 42 U.S.C. § 1395c. The Act charges the Secretary with compensating local hospitals, consistently with congressional direction, for the services they provide to beneficiaries. *Id.* §§ 1395d, 1395f; *see In re Medicare Reimbursement Litig.*, 414 F.3d 7, 8-9 (D.C. Cir. 2005) (describing Medicare reimbursement system), *cert. denied, Leavitt v. Baystate Health Sys.*, 126 S. Ct. 1672 (2006).

A hospital becomes a Medicare provider by entering into an agreement with the Secretary, 42 U.S.C. § 1395cc, under which the hospital commits to providing authorized services to eligible Medicare beneficiaries in exchange for payment, as reflected in the statute and implemented by the Secretary, 42 U.S.C. §1395cc(a). The hospital further agrees that the statutorily authorized reimbursement will be accepted as payment in full, irrespective of the hospital's actual expenses. *Id.*

Since 1983, under the Prospective Payment System, most hospitals providing inpatient Medicare services, including respondents, have been paid a fixed amount for each patient discharged. 42 U.S.C. § 1395ww(d) (2006 & Supp. IV 2010). This reimbursement is based on prospectively determined standardized rates that reflect average costs, and thus do not necessarily capture actual costs in individual cases. *See County of Los Angeles v. Shalala*, 192 F.3d 1005, 1008 (D.C. Cir. 1999). Congress accordingly directed the Secretary to

supplement those payments with hospital-specific adjustments that reimburse the higher-than-average costs per case reasonably incurred in the efficient delivery of health care. 42 U.S.C. § 1395ww(d)(5).

2. One of those adjustments is known as the "disproportionate share hospital adjustment" ("DSH adjustment"). Congress has long recognized that "low-income medicare patients" are generally more costly to treat because they commonly arrive at hospitals "in poorer health *** [and] tend to have more complications, secondary diagnoses and fewer alternatives for out of hospital convalescence than other patients." H.R. Rep. No. 241, 99th Cong., 1st Sess. 16 (1985). Congress also found that provider hospitals that have a particularly large share of low-income patients (whether or not Medicare participants) have "extra overhead costs and higher staffing ratios which reflect the special need for such personnel as medical social workers, translators, nutritional and health education workers." *Id.* Congress thus enacted the DSH adjustment to ensure adequate compensation for each hospital that "serves a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives depend on the hospital's "disproportionate patient percentage." 42 U.S.C. § 1395ww(d)(5)(F)(v). That percentage "is a 'proxy measure for low income'" patients. Pet. App. 14a (quoting H.R. Rep. No. 241, *supra*, at 16-17). It is computed through a statutory formula comprising the sum of two fractions, referred to as the "Medicaid Fraction" and the "SSI Fraction." 42 U.S.C. § 1395ww(d)(5)(F)(vi).

This case involves a dispute over calculation of the latter fraction. In simple terms, the "SSI Fraction" captures how many days of hospital care are provided to patients entitled both to benefits under Medicare Part A and supplemental security income, as a proportion of the total days of hospital care provided to patients entitled to benefits under Medicare Part A. 42 U.S.C. § 1395ww(d)(5)(F(vi)(I).

The Center for Medicare & Medicaid Services ("CMS") calculates the SSI Fraction each fiscal year and supplies that number to the "fiscal intermediaries," which are contracted agents of CMS charged with calculating and paying hospitals' Medicare claims. 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.1, 421.3; *see generally* 42 C.F.R. §§ 421.100-421.128. The intermediary, in turn, uses the Medicaid and SSI Fractions to calculate each hospital's disproportionate patient percentage and, from that, to determine the appropriate DSH payment adjustment. That adjustment amount is then added to the standardized reimbursement amount for each Medicare Part A patient served by that hospital. *See* 42 C.F.R. § 412.106(b).

Of the nearly 3,000 hospitals that receive DSH adjustment payments, approximately 20% are State and local government hospitals and nearly two-thirds are not-for-profit hospitals.[1] For state-owned

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[1] A listing of all Medicare hospitals, along with ownership information, is available at https://data.medicare.gov/dataset/Hospital-General-Information/V287-28n3. The DSH percentages of all applicable hospitals are listed at http://www.hrsa.gov/opa/dsh.htm. The statistics were calculated by using the provider number to transpose the DSH percentages for all of the DSH hospitals onto the larger set of

hospitals, DSH adjustments have accounted for an additional 24% of payments over Medicare's base reimbursement. *See* note 1, *infra*. For hospitals owned by local governments or operated by local hospital districts or authorities, the DSH adjustments have constituted roughly 17% of the base payments. That same figure was roughly 13% for not-for-profit hospitals. *Id.*

At the end of each fiscal year, Medicare-participating hospitals file cost reports with their fiscal intermediaries. 42 C.F.R. § 413.20(b).[2] After reviewing the reports, the intermediary issues a "Notice of Program Reimbursement" that advises the hospital how much it will be paid. *See* 42 C.F.R. § 405.1803(a)(2). In determining that payment amount, the intermediary must use the SSI Fraction calculated by the Secretary, which is based on data the agency alone possesses. 42 C.F.R. § 412.106(b).

3. In 1972, Congress set up an administrative and judicial review process for providers to challenge intermediary payment determinations. The Provider Reimbursement Review Board ("Board"), composed of five persons appointed by the Secretary, offers a forum for a "provider *** dissatisfied with [an intermediary's] final determination" to obtain review of the intermediary's decision. 42 U.S.C.

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all Medicare hospitals. The roughly 25 hospitals that appear on the listing of DSH hospitals, but not on the listing of Medicare hospitals (presumably because they have closed, changed ownership, *etc.*, since the DSH list was updated), were excluded from the calculations.

[2] Unless otherwise indicated, all references are to the 2007 edition of 42 C.F.R., which governs this case. *See* Pet. App. 15a n.3.

§ 1395*oo*(a); *see* Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1329, 1420 (1972). "Any provider," including a Medicare participating hospital, "may obtain" a Board hearing if "dissatisfied with a final determination [by a fiscal intermediary]," or with the Secretary's determination of the "amount of the payment" to be received during a fiscal year. 42 U.S.C. §§ 1395*oo*(a)(1)(A)(i) & (ii). A hospital may also obtain a Board hearing if it has not received a determination from the Secretary or the intermediary on "a timely basis." 42 U.S.C. §§ 1395*oo*(a)(1)(B) & (C). Congress authorized Board hearings for provider challenges involving an "amount in controversy [of] $10,000 or more." 42 U.S.C. § 1395*oo*(a)(2). Congress further provided that such Board review is available when the provider "files a request for a hearing within 180 days after notice of the intermediary's final determination." 42 U.S.C. § 1395*oo*(a)(3).

Congress envisioned that the Board proceedings would have flexible and adaptable hearing procedures. To that end, Congress authorized the Board to receive evidence, "even though inadmissible under rules of evidence applicable to court procedure." 42 U.S.C. § 1395*oo*(c). Congress also did not limit the scope of Board review to only those issues and evidence presented to the intermediary. Instead, it authorized the Board to base a decision not only on "the evidence considered by the intermediary," but also on any "such other evidence as may be obtained *** by the Board." 42 U.S.C. § 1395*oo*(d). In addition, Congress authorized the Board to "affirm, modify, or reverse" an intermediary's final determination on grounds "not

considered by the intermediary in making such final determination." *Id.*

The Board's determination is a final decision subject to judicial review unless modified by the Secretary. 42 U.S.C. § 1395*oo*(f)(1). The Secretary may "reverse[], affirm[], or modif[y] the Board's decision" within sixty days. *Id.* If the provider is still dissatisfied with the Board's or Secretary's final decision, it may obtain "judicial review" in federal district court. *Id.*

4. For decades, by both regulation and practice, the Secretary has expanded the opportunities for providers to obtain Board review of intermediary determinations beyond the minimum criteria set forth in Section 1395*oo*(a)(3). In particular, the Secretary has recognized since shortly after Section 1395*oo*(a)(3)'s enactment that the 180-day filing deadline is neither mandatory nor jurisdictional. In 1974, the Secretary expressly authorized the Board to hear claims filed after the 180-day time period has expired "for good cause shown." 20 C.F.R. § 405.1841(b) (1974). The Secretary, however, also imposed an absolute three-year limit on providers' access to the good-cause exception. *Id.*[3]

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[3] In 2008, after the litigation in this and related cases commenced, the Secretary amended the good-cause regulation for the first time in thirty-four years, confining it to situations in which "the provider demonstrates *** [that] it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike)[.]" 42 C.F.R. § 405.1836(b) (2011). The amended regulation also prohibits the Board from granting an extension request based on "a change in the law,

In addition to the good-cause exception, the Secretary's regulations allow a provider to obtain relief from a final payment determination by requesting "reopen[ing]" of an intermediary's determination or of a prior decision by the Board within three years of the date of notice of that hearing. 42 C.F.R. § 405.1885(a). Also, a final payment determination "shall be reopened" at any time if there is a showing of "fraud or similar fault of any party to the determination or decision," *id.* at § 405.1885(d). According to the Secretary's brief in this Court, "party" in that regulation does not include the Secretary, CMS, or the intermediary. *See* SG Br. 7-8 n.5.[4]

Under the Secretary's interpretation of the reopening regulation, SG Br. 7-8 n.5, the agency may go back in time indefinitely to recover overpayments based on "fraud or similar fault" of a provider. But providers have no similar right to reopening for "fraud or similar fault" by the Secretary or her contractor.

The decision regarding a request for reopening of an intermediary determination "rests exclusively with that administrative body that rendered the last

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regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy." *Id.* § 405.1836(c)(1) (2011).

[4] When being formulated, the proposed reopening rule provided that a payment determination "shall be reopened" based on a showing of "fraud or similar fault of the provider." 39 Fed. Reg. 8,166, 8,170 (Mar. 4, 1974). In adopting the final rule, the agency modified the provision to provide for reopening based on "fraud or similar fault of any party." 39 Fed. Reg. 34,514, 34,515 (Sept. 26, 1974).

determination or decision," 42 C.F.R. § 405.1885(c), except that the Secretary may reverse a decision to reopen or not to reopen, "[n]otwithstanding an intermediary's discretion," *id.* § 405.1885(e). In *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449, 453 (1999), this Court ruled that an intermediary's denial of a request for reopening is not a "'final determination'" subject to Board review under 42 U.S.C. § 1395*oo*(a)(1)(A)(i).

B. Procedural History

1. Soon after Congress adopted the DSH adjustment, the Secretary announced that CMS would release to providers and intermediaries only the summary results of its calculation of the SSI Fraction and not the underlying data. *See* 51 Fed. Reg. 31,454, 31,459 (Sept. 3, 1986). CMS is supposed to retrospectively calculate the SSI Fraction by "matching individual Medicare billing records to individual SSI records" to determine the percentage of patient days for individuals who were entitled to benefits under Part A and were also entitled to SSI benefits. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 23 (D.D.C. 2008), *amended on other grounds*, 587 F. Supp. 2d 37 (D.D.C. 2008). CMS is also supposed to obtain SSI eligibility data from the Social Security Administration. *Id.* Because, during the years at issue, the Secretary refused to release the underlying data, hospitals had no ability to verify the Secretary's calculations or, in particular, to determine which patient days should have been but were not counted in the SSI numerator. *See* 61 Fed. Reg. 46,166, 46,206 (Aug. 30, 1996) ("Since SSI beneficiary information is confidential, hospitals do not have access to lists of patients ***. Hospitals are

increasingly frustrated by their inability to monitor these data.").

2. In 2006, after extensive litigation, Baystate Medical Center was able to obtain SSI records for a small sample of its patients. *See Baystate Med. Ctr.*, 2006 WL 752453, at *3. As the Board found, those records uncovered for the first time that, for at least fiscal years 1993 through 1996, (i) the Secretary was knowingly using incomplete and outdated data, rather than the best available data, in calculating the SSI fraction; (ii) the Secretary compounded the miscalculation by using a flawed match process that omitted categories of patients; and (iii) those systemic errors improperly deflated the DSH payment. *Id.* at *20, *33-34.

The Board also found that the Secretary's actual process for matching patients to SSI benefits materially departed from the Secretary's representations in the Federal Register. *Baystate*, 2006 WL 752453, at *10 ("However, despite CMS' stated intent to use Social Security numbers as the patient match criteria, [51 Fed. Reg. 16,772, 16,777 (May 6, 1986)] the evidence showed that CMS has never matched Social Security numbers" between the Social Security Administration and Medicare data files.). The Board admonished one CMS employee for being "a bit disingenuous" when she testified at a deposition regarding her inability to recall relevant events. *Id.* at *28 n.210. She testified that a "DSH payment issue involving 'a few hundred million dollars' would '[n]ot necessarily' have left a lasting impression on her, 'given the amount of money involved.'" *Id.* at *28 (alteration in original).

CMS did not disclose the error to affected hospitals. *Baystate Med. Ctr.*, 2006 WL 752453, at *27. Two years after it learned of data problems, but before taking any corrective action, CMS represented that "the SSI data used in the calculation of the SSI fraction were verified and correct." *Id.* at *27. It likewise stated that the "data that the Social Security Administration (SSA) uses to determine the Medicare Part A/SSI percentage are not released to [CMS]," 60 Fed. Reg. 45,778, 45,812 (Sept. 1, 1995), even though the data were released to CMS, and it was CMS, and not the SSA, that in fact performed the calculation. *See id.* at *8. CMS never provided an explanation for its failure to correct past calculations. *Id.* at *28.

The district court in *Baystate* affirmed the Board, finding that CMS was aware "as early as 1993 *** that there was *** something wrong with the numbers." 545 F. Supp. 2d at 44, 45 (internal quotation marks omitted). The court also found that, notwithstanding its recognition of problems with its past calculations in 1996, CMS made only prospective corrections. *Id.* at 27.

Beyond problems with the source data, the *Baystate* district court further found that, throughout the relevant period, CMS failed to use available and reliable patient identifiers for the match process (*i.e.*, Social Security Numbers), and may have used a patient identifier that systematically undercounted many SSI records, 545 F. Supp. 2d at 46-48.

Finally, the district court affirmed Baystate's right to retrospective recalculation of the DSH payments because "CMS and [the Social Security Administration] were in sole possession of the SSI

data necessary to determine the scope of the impact with any greater precision." 545 F. Supp. 2d at 51. "[T]he interest in administrative finality carries far less weight for DSH payments," the court ruled, because the nature of the calculation is entirely retrospective. *Id.* at 52. The court also ruled that CMS could not defend its position by arguing for predictability for providers because the agency claimed for itself the authority to recalculate the payment whenever it desires. *Id.* at 53 n.33. Finally, the court ruled that "the denial of relief here would have the perverse effect of rewarding CMS for ignoring the best available data." *Id.* at 54.

3. Within 180 days after publication of the Board's decision in *Baystate,* the respondent Hospitals sought a Board hearing to correct underpayments in their earlier-filed cost reports for fiscal years 1987 to 1994 pursuant to 42 U.S.C. § 1395*oo*(a). The complaint explained that the Hospitals could not previously have challenged the payments because of the Secretary's unilateral control over the necessary information and its decision not to advise providers of its erroneous calculations. J.A.35.[5]

The Hospitals acknowledged that their hearing requests were filed outside of Section 1395*oo*(a)(3)'s 180-day timeframe and the regulatory good-cause window, 42 C.F.R. § 405.1841(b). Pet. App. 52a. The Hospitals argued, however, that the time limit should be equitably tolled due to "CMS' alleged knowing and unlawful refusal to inform hospitals

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[5] There is no dispute that the Hospitals' initial cost reports for the time periods at issue were timely filed.

that the SSI percentage was incorrectly stated for the fiscal years under appeal." *Id.* at 53a.

The Board ruled that it "lack[ed] jurisdiction" over the Hospitals' challenge, because it "was not timely filed" either under Section 1395*oo*(a)(3) or the good-cause exception. Pet. App. 55a. The Board said that, as "an administrative forum," it had "only the powers granted to it by statute and regulation." *Id.* In the Board's view, its "equitable powers" were confined to the terms of the good-cause and reopening regulations, neither of which it believed applied here. *Id.* at 55a-56a.

4. The Hospitals filed suit in the United States District Court for the District of Columbia under 42 U.S.C. § 1395*oo*(f)(1), 28 U.S.C. § 1331, and 28 U.S.C. § 1361, seeking review of the Board's decision. *See* Pet. App. 11a-50a. The district court acknowledged "at the outset" that "the 180-day limitations period cannot plausibly be characterized as jurisdictional." *Id.* at 24a. The court nevertheless rejected the argument that Section 1395*oo*(a)(3)'s time limit was presumptively subject to equitable tolling on the ground that the Hospitals had "proffered nothing suggesting that *** Congress intended to authorize equitable tolling for provider claims." *Id.* at 30a, 40a.

5. The court of appeals unanimously reversed. Pet. App. 1a-10a. The court stated that "'[i]t is hornbook law that limitations periods are customarily subject to equitable tolling unless tolling would be inconsistent with the text of the relevant statute.'" *Id.* at 5a-6a. The court then held that the presumption in favor of equitable tolling applies because Section 1395*oo*(a)'s language was "similar to

other statutes that have been held to permit equitable tolling." *Id.* at 6a-7a.

The court rejected (Pet. App. 7a-10a) the government's reliance on *United States v. Brockamp*, 519 U.S. 347 (1997), stressing that Section 1395*oo*(a)'s language "resembles the 'fairly simple'" statutory language that *Brockamp* considered to be subject to equitable tolling, and does not "'set[] forth its limitations in a highly detailed technical manner,'" nor "'reiterate[] its limitations several times in several different ways,'" in contrast to the tax refund provision at issue in *Brockamp*. *Id.* at 7a-9a (quoting *Brockamp*, 519 U.S. at 350, 351). The court additionally explained that, "unlike the statute at issue here," the tax statute in *Brockamp* "'set[] forth explicit exceptions to its basic time limits.'" *Id.* at 8a (quoting *Brockamp*, 519 U.S. at 351).

The good-cause exception did not buttress the Secretary's position, in the court's view, because "that exception is in the regulations, not the statute." Pet. App. 9a. The court also ruled that the complexity of the Medicare scheme was irrelevant to the equitable tolling inquiry since "the Court's focus in *Brockamp* was not the complexity of tax law per se, but rather the complexity of the provisions governing whether and when a claim could be filed." *Id.* "[U]nlike the tax code," the panel concluded, the Medicare statute "does not create a detailed Jenga tower of deadlines and exceptions that equitable tolling might topple." *Id.* at 10a.

Finally, "without any other reasons for rebutting the presumption of equitable tolling," the court held that equitable tolling is available under Section 1395*oo*(a), but left for "further factual development" on remand the "different question" of whether

"tolling is appropriate in this particular case." Pet. App. 10a.

6. The Secretary's petitions for rehearing and rehearing en banc were denied. Pet. App. 61a-62a; 63-64a. Concurring in the denial of rehearing en banc, Judge Griffith and Senior Judge Williams reiterated that "the statute itself is without any clues that suggest Congress barred equitable tolling," and contrasted the simple time limitation set forth in Section 1395*oo*(a)(3) with the tax code provision at issue in *Brockamp*. Pet. App. 65a.

SUMMARY OF ARGUMENT

I. The 180-day time period for a Medicare provider to seek review of a compensation determination by the Provider Reimbursement Review Board, 42 U.S.C. § 1395*oo*(a)(3), is a quintessential claim-processing rule that is subject to extension without jurisdictional consequence. The timeframe for Board review is virtually indistinguishable in wording and design from a number of other statutory limitations periods that this Court has repeatedly held are nonjurisdictional. Nothing in Section (a)(3)'s language or structure indicates, let alone clearly states, that Congress invested the time limit with jurisdictional import.

To imbue the filing window with strict jurisdictional force even when the agency has knowingly concealed its own known errors, moreover, would be at cross-purposes with (a)(3)'s intended function of ensuring that Medicare providers have a meaningful opportunity for administrative (and then judicial) review of agency payment determinations. Finally, the Secretary has long treated (a)(3) as nonjurisdictional without any

objection or correction by Congress when it repeatedly revisited the statute, including a specific amendment to Section 1395*oo*.

II. The settled rule is that limitations periods like that in Section 1395*oo*(a)(3) are subject to equitable tolling. The presumption is so engrained in the law and practice that this Court has held that it is the most accurate barometer of congressional intent, which is what ultimately controls the equitable tolling inquiry. That presumption applies with full force to (a)(3). The statutory text and structure are fully consistent with tolling, paralleling the type of statutory language that this Court time and again has held is subject to equitable tolling. The provision is, moreover, largely self-contained, making the application of equitable tolling straightforward and administrable.

Tellingly, the government does not, and cannot, argue that Congress barred the Board from hearing provider requests filed outside the 180-day deadline. Instead, the government fights to have its cake and eat it too, defending a one-way, inequitable tolling rule under which the Secretary is eternally free to reopen and recoup overpayments based on fraud or similar fault by the provider, without any showing of due diligence, while depriving diligent providers hurt by agency misconduct of any realistic opportunity to obtain the payments that Congress promised it would pay.

That argument is wrong. *First*, equitable tolling is a question of congressional intent, and the statutory construction rules that evaluate equitable tolling for judicial review provisions are at least equally indicative of congressional intent with respect to administrative review provisions. Indeed,

the presumption of equitable tolling applies at *Chevron* step one and thus, in this case, leaves no ambiguity for the agency to address.

That is particularly true when, as here, the administrative review process operates in tandem with a judicial review provision that is fully subject to the presumption in favor of tolling. Congress intended administrative review to facilitate judicial review and to give the agency the first crack at redressing its own errors. It did not intend to make the administrative process a backdoor cutoff of all meaningful review, administrative and judicial, of agency misconduct.

Second, fundamental tenets of administrative law require that a party whose interests are being adjudicated have reasonable access to the basic information underpinning the agency's determination, and the right to challenge that determination after it is disclosed. An agency cannot, through regulations, help itself out of the very review of its own actions that Congress ordered.

Third, the application of settled, evenhanded tolling principles fully comports with the statutory design; ceding control of the tolling process to the very agency whose actions Congress wanted scrutinized would confound it. More specifically, the whole point of the Board's process is to provide meaningful review and correction of erroneous agency determinations. To allow the agency's affirmative concealment of known errors to defeat the very review designed to remediate such errors in the first place would stand congressional purpose on its head.

ARGUMENT

I. THE 180-DAY TIMEFRAME FOR BOARD REVIEW IS A QUINTESSENTIAL CLAIM-PROCESSING RULE THAT IS SUBJECT TO EXTENSION.

The text of Section 1395*oo*(a)(3) straightforwardly establishes that the 180-day window for seeking review by the Medicare Provider Reimbursement Review Board is just that: a traditional filing period that prescribes when providers are to take certain procedural steps. The relevant statutory language is devoid of jurisdictional references or constraints. Its focus is on ensuring that providers "may obtain" review if desired, not rigidly constraining the Board's power to act. Furthermore, the purpose for which Congress created the Board was to afford providers a fair opportunity to obtain the full compensation that Congress promised—neither more nor less—for services already provided on the understanding that the government would keep its compensation word. There thus is no sound basis for concluding that Congress intended to woodenly bar innocent providers from obtaining their deserved reimbursement where the Secretary's knowing withholding of critical information foreclosed any meaningful challenge to the compensation determination earlier. The 180-day timeframe for seeking review, in short, is part of a statutory scheme meant to promote, not impede, the proper compensation of providers.

A. The Statutory Text And Structure Create An Ordinary Claim-Processing Rule.

In an effort to "reduce confusion, clouding court as well as Board decisions, over matters properly typed 'jurisdictional,'" *Union Pac. R.R. Co. v. Brotherhood of Locomotive Eng'rs & Trainmen Gen. Comm. of Adjustment*, 130 S. Ct. 584, 596 (2009), this Court has adopted a "readily administrable bright line" rule for differentiating jurisdictional and nonjurisdictional limitations in a statute, *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 516 (2006). "A rule is jurisdictional" only '[i]f the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional.'" *Gonzalez v. Thaler*, 132 S. Ct. 641, 648 (2012) (quoting *Arbaugh*, 546 U.S. at 515). Under that "clear-statement principle," *Gonzalez*, 132 S. Ct. at 649, unless Congress itself "'rank[s] a statutory limitation on coverage as jurisdictional, courts should treat the restriction as nonjurisdictional,'" *id.* at 648 (quoting *Arbaugh*, 546 U.S. at 516).

Nowhere in the text of Section 1395*oo*(a)(3) did Congress rank the Board filing period as jurisdictional. Quite the opposite, viewed from every angle, Congress framed the 180-day filing period as the very type of routine "claim-processing rule[]" that this Court has said "should not be described as jurisdictional." *Henderson v. Shinseki*, 131 S. Ct. 1197, 1203 (2011); *see Reed Elsevier, Inc. v. Muchnick*, 130 S. Ct. 1237, 1246 (2010) (courts should look to "text, context, and relevant historical treatment" to discern whether a provision has jurisdictional force).

First, this Court has held that "[f]iling deadlines, such as the 120-day filing deadline at issue here, are quintessential claim-processing rules." *Henderson*, 131 S. Ct. at 1203. Indeed, time and again, this Court has held that similar filing deadlines are nonjurisdictional, procedural rules. *See, e.g.*, *Kontrick v. Ryan*, 540 U.S. 443, 454 (2004) (Chapter 7's sixty-day period to object to the debtor's discharge in bankruptcy proceeding is a claim-processing, not a jurisdictional, matter); *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 393 (1982) (Title VII provision requiring complainants to file a charge of discrimination with the EEOC within 90 days of the alleged discriminatory act is nonjurisdictional); *Burnett v. New York Cent. R.R. Co.*, 380 U.S. 424, 426-427 (1965) (three-year statute of limitations for actions under FELA not jurisdictional); *Honda v. Clark*, 386 U.S. 484, 495-496 (1967) (60-day time limit on filing claims under the Trading with the Enemy Act is nonjurisdictional).

Such filing deadlines do not "speak to the power" of the tribunal, but rather address the "'rights or obligations of the parties.'" *Reed Elsevier*, 130 S. Ct. at 1243. In so doing, they "seek to promote the orderly progress of litigation by requiring that the parties take certain procedural steps at certain specified times." *Henderson*, 131 S. Ct. at 1203.[6]

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[6] The exceptions that prove the rule are a limited subset of court filing deadlines that have a long tradition of treatment as jurisdictional and in which "Congress has long acquiesced." *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 139 (2008) (Court of Claims suits against the United States); *see Bowles v. Russell*, 551 U.S. 205, 210-213 (2007) (court-to-court

So too here. Section 1395*oo*(a)(3) does not speak to the Board's power, authority, or capacity to act. Quite the opposite, the statutory language focuses on the providers seeking compensation and affords them an orderly procedural path to review. Indeed, Section 1395*oo*(a)(3) does not mention the "Board" a single time. Instead, (a)(3), like its neighboring statutory provisions, simply identifies the opportunity for review that Congress created for providers and outlines how "a provider may obtain a hearing" if dissatisfied with the intermediary's or agency's reimbursement.

Second, the provision does not differ in any material way from the nonjurisdictional time limit for review by a non-Article III "tribunal as part of a unique administrative scheme" that this Court found in *Henderson*, 131 S. Ct. at 1204. Both simply lay out a time in which, following notice of an initial agency determination, the objecting party is to request review by the designated tribunal. *Compare* 42 U.S.C. § 1395*oo*(a) (3) ("Any provider *** may obtain a hearing *** if *** [it] files a request for a hearing within 180 days after notice of the

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notices of appeal). Here, for nearly forty years, most courts and the Executive Branch's published regulations have treated the filing time as nonjurisdictional and subject to equitable exceptions. *See* 20 C.F.R. § 405.493 (1973); 42 C.F.R. § 405.1836(a) (2011); *Western Med. Enters. v. Heckler*, 783 F.2d 1376 (9th Cir. 1986); *Bradford Hosp. v. Shalala*, 136 F. Supp. 2d 428 (W.D. Pa. 2001); *Ozark Mountain Reg'l Rehab Ctr. v. DHHS*, 798 F. Supp. 16 (D.D.C. 1992); *but cf. St. Joseph's Hosp. v. Heckler*, 786 F.2d 848 (8th Cir. 1986) (concluding, with no recognition of the distinction between claim-processing rules and jurisdictional bars, that (a)(3) is jurisdictional); *Alacare Home Health Servs., Inc. v. Sullivan*, 891 F.2d 850 (11th Cir. 1990) (same).

intermediary's final determination[.]"), *with* 38 U.S.C. § 7266(a) ("In order to obtain review by the Court of Appeals for Veterans Claims of a final decision of the Board of Veterans' Appeals, a person adversely affected *** shall file a notice of appeal with the Court within 120 days after the date on which notice of the decision is mailed[.]"). Indeed, there is even *less* basis for finding a rigid limitation here because Congress omitted the traditionally jurisdictional "notice of appeal" language that was present in *Henderson*'s statutory text.

Third, Section 1395*oo*(a)(3)'s text confirms its nonjurisdictional operation. Congress nowhere labeled the timeframe as jurisdictional. The provision also "does not speak in jurisdictional terms" in any other respect "or refer in any way to the jurisdiction of the [Board]." *Zipes*, 455 U.S. at 394. Nor does it address the scope of the Board's adjudicatory authority. Instead it speaks spaciously and in non-prohibitory terms about what *providers* are to do "to obtain a hearing" with respect to different categories of administrative decisions. 42 U.S.C. § 1395*oo*(a)(3). Thus, as in *Henderson*, the focus and contours of the relevant text are incompatible with a jurisdiction-assigning rule.

Amicus emphasizes (Br. 19, 28) the labeling of Section 1395*oo*(a) as the "Establishment" of the Board. That is not a traditionally jurisdictional term either. In any event, "Establishment" is not Congress's word. It appears nowhere in the Medicare Public Laws enacted by Congress since the Board's creation. Instead, "Establishment" appears to be a choice of the codifiers that, accordingly, says nothing about congressional intent. The "intent of Congress is to be derived from the language and

structure of the statute itself, if possible, not from the assertions of codifiers." *United States v. Lanier*, 520 U.S. 259, 267 n.6 (1997). "Certainly where, as here, the [caption was added] by a codifier without the approval of Congress, it should be given no weight." *United States v. Weldon*, 377 U.S. 95, 98 n.4 (1964).[7]

Fourth, contrary to the argument of Amicus (Br. 19-22), the surrounding statutory criteria for Board review, such as the requirements that the provider be "dissatisfied" with a compensatory determination, 42 U.S.C. § 1395*oo*(a)(1), or the amount in controversy requirement, *id.* § 1395*oo*(a)(2), do not clearly speak in jurisdictional terms. Neither (a)(1) nor (a)(2) uses jurisdictional language, addresses the Board's power to act, or even mentions the Board. Instead, like (a)(3), both speak to the rights of the provider and the characteristics of its claim. *See Reed Elsevier*, 130 S. Ct. at 1247 (that 17 U.S.C.

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[7] "Establishment" appears only in the margin notes of the Statutes at Large, not in the Public Laws. Such margin notes, made by codifiers not Congress, "do not have the force of law." *United States v. Vazquez*, 271 F.3d, 93, 111 (3d Cir. 2001). *See* An Act to Amend the Social Security Act, and For Other Purposes, Pub. L. 92-603, § 243(a), 86 Stat. 1420 (1972); An Act to Suspend for a Temporary Period the Import Duty on Certain Horses, and For Other Purposes, Pub. L. 93-484, § 3(a), 88 Stat. 1459 (1974); Omnibus Reconciliation Act of 1980, Pub. L. 96-499, § 955, 94 Stat. 2674 (1980); Social Security Amendments of 1983, Pub. L. 98-21, § 602(h), 97 Stat. 165 (1983); Deficit Reduction Act of 1984, Pub. L. 98-369, §§ 2351(a)(1), (b)(1), 2354(b)(39), (40), 98 Stat. 1098, 1099, 1102 (1984); Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, § 4161(a)(6), (b)(4), 104 Stat. 1388-94, 1388-95 (1990); Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, § 13503(c)(1)(B), 107 Stat. 579 (1993).

§ 411(a) imposes preconditions to filing suit under the Copyright Act did not render those preconditions jurisdictional).

Fifth, with respect to (a)(1) in particular, its language lacks the precision, formality, and determinativeness generally associated with jurisdictional triggers. For example, the provider may seek review if it is "dissatisfied" with the reimbursement computed by the intermediary, a fairly flexible, indeterminate, and less-than-objective term that, to respondents' knowledge, Congress has not before employed in the United States Code to draw jurisdictional lines. Instead, Congress not uncommonly employs similar "dissatisfaction" phraseology when simply identifying opportunities for individuals to obtain administrative review. *See, e.g.*, 7 U.S.C. § 1363 ("Any farmer who is dissatisfied with his farm marketing quota may *** have such quota reviewed by a local review committee[.]"); 20 U.S.C. § 1412(a)(10)(A)(v)(II) ("If the private school official is dissatisfied with the decision of the State educational agency, such official may submit a complaint to the Secretary[.]"); 42 U.S.C. § 421(d) ("Any individual dissatisfied with any determination under [certain] subsection[s] [related to individual disability claims] *** shall be entitled to a hearing[.]").[8]

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[8] Although this Court once referred to "a provider's dissatisfaction with the amount of its total reimbursement" as "a condition to the Board's jurisdiction," *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 403, 404 (1988), that was at a time when the Court was "less than meticulous" with its invocation of "jurisdictional" labels, *Arbaugh*, 546 U.S. at 511. Furthermore, in *Bethesda Hospital*, the "parties agree[d]" to

Relatedly, two of (a)(1)'s sub-provisions turn on whether the provider did not receive a final determination "on a timely basis," 42 U.S.C. §§ 1395*oo*(a)(1)(B) & (C), which again is not the type of definitive and concrete factor on which Congress generally would irrevocably hinge all prospects of further administrative or judicial review of a legal claim.

Moreover, for decades without congressional objection, the Board has been empowered to issue decisions on matters other than those specifically listed in Section 1395*oo*(a). For example, the Board's review process is used for hospitals' challenges to the specific diagnosis-related group assigned to their inpatient stays, even though such review would not be "with respect to [a] cost report," or a "final determination," as Section 1395*oo*(a) and (a)(1) require. *See* 52 Fed. Reg. 33,034, 33,047 (Sept. 1, 1987).

Sixth, Section 1395*oo*(a)(2)'s amount-in-controversy requirement is not jurisdictionally absolute either. The Board has construed that limitation flexibly, deeming the amount in controversy requirement to be satisfied by, for example, considering multiple fiscal years in a single appeal. *See* 42 C.F.R. § 405.1839(b)(2)(ii) (2011) (permitting providers to aggregate claims for two or more fiscal years in order to meet the minimum

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call it jurisdictional, 485 U.S. at 403, and the Court accordingly did not focus directly on the question, rendering that reference the type of "drive-by jurisdictional" comment that is "accorded no precedential effect," *Arbaugh*, 546 U.S. at 511 (internal quotation marks omitted).

amount in controversy requirement for group appeals).

Amicus suggests (Br. 21) that, because an "amount in controversy" requirement in some statutes is jurisdictional, *see* 28 U.S.C. § 1332, it necessarily must be so here. But that is not how this Court analyzes the jurisdictional import of statutory provisions. In *Henderson*, the statute required claimants to file a "notice of appeal," 38 U.S.C. § 7266(a), phraseology that is traditionally treated as jurisdictional, *see Bowles v. Russell*, 551 U.S. 205, 210-213 (2007). Yet this Court held that the time limit on filing notices of appeal to the Veterans Court in *Henderson* was not jurisdictional. 131 S. Ct. at 1204.

Likewise here, while Congress undoubtedly intended the amount in controversy requirement to be satisfied, there is no clear statement in the text or structure of Section 1395*oo*(a) that the amount was meant to have disabling jurisdictional force or that its strict satisfaction is so critical to the Board's adjudicatory authority that belated discovery of an amount in controversy defect in a case would mandate overturning all of the Board's work after the fact. *Henderson*, 131 S. Ct. at 1202 (discussing the "drastic" "consequences that attach to the jurisdictional label," including after-the-fact vacatur of decisions resulting in "many months of work on the part of the attorneys and the court *** be[ing] wasted").

Beyond that, whatever jurisdictional effect (a)(2)'s amount in controversy requirement might suggest, the meaning of (a)(3) must be evaluated independently because there is no rule of jurisdiction by association. "[M]ere proximity will not turn a

rule that speaks in nonjurisdictional terms into a jurisdictional hurdle." *Gonzalez*, 132 S. Ct. at 651. Thus, jurisdictional and nonjurisdictional provisions can comfortably coexist on the same page and within the same provision of the United States Code, without merging identities. *See id.*; *Weinberger v. Salfi*, 422 U.S. 749, 763-764 (1975) (requirement of a "final" benefit decision "made after a hearing" is "central to the requisite grant of subject-matter jurisdiction," but the "second and third of these requirements specify, respectively, a statute of limitations and appropriate venue," and thus "are waivable by the parties").[9]

Finally, Congress itself directed that the Board's subject-matter jurisdiction is not constrained by the terms of the provider request, or even by the record of the intermediary determination. *See* 42 U.S.C. § 1395*oo*(d) (Board can consider evidence not submitted to the intermediary and rule upon "matters [that] were not considered by the intermediary in making such final determination,"

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[9] By the same token, the nonjurisdictional character of (a)(3) is reinforced, not metamorphosized, by the existence of another *nonjurisdictional* provision later in the statute that establishes specifically permits regulatory exceptions to a statutory deadline for Medicare beneficiary claims. *See* 42 U.S.C. § 1395ff(b) (Supp. II 1973, incorporating by reference, 42 U.S.C. § 405(b)(1970)). The existence of tolling provisions elsewhere in the statute shows that the law "*incorporates* traditional equitable principles." *Young v. United States*, 535 U.S. 43, 53 (2002). Moreover, the availability of tolling in a related benefit-payment process, *Bowen v. City of New York*, 476 U.S. 467 (1986), demonstrates that where, as here, administrative review is a precondition for ultimate judicial review, the deadline is nonjurisdictional and tolling is allowed.

including finding "revisions adverse to the provider"); *cf. Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) (Board may not refuse to consider a hospital's challenge to a regulation on the ground that the hospital followed the regulation in the cost report submitted to the intermediary).

B. The Statutory Context And Purpose Confirm That The Time Limit Is Nonjurisdictional.

The statutory context and purpose of the Medicare program and provider reimbursement scheme confirm what the statutory text already indicates: the 180-day timeframe is a claim-processing rule that may be extended, rather than a jurisdictional bar. *See Henderson*, 131 S. Ct. at 1205 (factoring the "singular characteristics of the review scheme" into determination that a time limit on notices of appeal was nonjurisdictional). The Board was established to provide the opportunity to correct payment errors, and thereby to ensure that local providers were reimbursed as Congress intended, before judicial review commences. The beneficial purposes of Medicare, the impact of reimbursement missteps on providers' continuing ability to deliver Medicare services, including in particular on State and local governments and non-profit providers, and the longstanding treatment of Section 1395*oo*(a)(3)'s timeframe as a claim-processing rule, all conclusively establish (a)(3)'s nonjurisdictional operation.

1. Medicare was enacted to make the best of modern medicine available to the elderly and disabled and to ensure that beneficiaries have access to high-quality medical care in their local communities. *See* S. Rep. No. 404, 89th Cong., 1st

Sess. 2 (1965) ("The overall purpose *** is *** to provide a coordinated approach for health insurance and medical care for the aged."). Indispensable to that goal are the boots-on-the-ground healthcare providers who are willing to deliver those critically needed medical services at congressionally specified rates that, in many individual cases, do not cover actual costs. That is particularly true for those hospitals eligible for the DSH adjustment, which incur particularly high expenses in treating their Medicare patients and rely critically upon proper DSH compensation in their provision of vital services to their communities. As the Secretary has recognized, if there were even a temporary reduction in DSH payments, "many [DSH] hospitals may experience financial difficulties that may adversely affect access to services by the low-income patients served by these safety net hospitals." *See* 65 Fed. Reg. 3136, 3137 (Jan. 20, 2000).

Construing the Board's review provision to facilitate claims for proper compensation and not to insulate the agency's knowingly hidden errors from correction comports with that congressional purpose. It ensures that providers obtain the payments that Congress promised, and that their right to fair compensation cannot be defeated by the agency's knowing suppression of its own errors until the clock runs out.

2. Amicus and the Secretary repeatedly characterize the providers as "sophisticated" entities that—they contend—can easily stomach the government's knowing deprivation of promised compensation for work already done. Those providers, they insist, are not entitled to the

"solicitude" accorded to the veterans in *Henderson*. *See* SG Br. 28, 35; Amicus Br. 13, 34.

While few if any can claim the solicitude to which veterans are entitled, that alone provides no sound basis for declaring jurisdictional a statute that—by all other indications—is a traditional claim-processing rule. The argument forgets, moreover, that a significant percentage of all Medicare providers and some 20% of the Medicare DSH providers are State and local governments. *See* note 1, *supra*, and accompanying text. When a federal agency hides the ball and does not pay State and local governments as Congress promised for services already rendered, those governments are effectively commandeered into implementing a federal program in part on their own dime, and their taxpayers are compelled locally to disproportionately subsidize what was supposed to be a national commitment to medical care for the elderly and disabled. This Court should not lightly assume that Congress intended to jurisdictionally foreclose State and local governments from holding the federal government to its compensatory word.[10]

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[10] Amicus argues that *Gonzalez's* "clear-statement principle" that claim-processing rules be treated as nonjurisdictional, *Gonzalez*, 132 S. Ct. at 648-649, is distinct from the clear-statement rule that is "used to protect a constitutional norm such as federalism." Br. 16 n.9 (citing, *inter alia*, *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991)). But, even assuming there can be degrees of "clear" statements, the important role that State and local governments frequently play as providers under the Medicare program and the federalism implications of construing the law to shift expenses from the federal fisc to State coffers defeat that argument. *Gonzalez's* clear statement rule, moreover, also enforces the constitutional separation of

In addition, non-profit hospitals make up another 60% of the Medicare DSH providers, and their budgets may well lack the room to absorb the federal government's knowingly unpaid bills. At a minimum, funds expended covering the federal government's share of Medicare reimbursement are not available for other not-for-profit services.

In Your Home Visiting Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1999), this Court observed that Medicare providers are "generally capable of identifying an underpayment *** within the 180-day time period," *id.* at 456. The operative word, though, is "generally." The archetypical exception to that general rule is when the federal agency, in unilateral control of the information used to compute reimbursements, knowingly missteps in those calculations, and then knowingly conceals the errors. No matter how "sophisticated" State and local government, for-profit, and not-for-profit providers may be (*see, e.g.*, US Br. 35; Amicus Br. 13), they are not clairvoyant.

Furthermore, all Medicare providers—public, for-profit, and not-for-profit alike—that render services to Medicare beneficiaries are contractually and statutorily entitled to the congressionally promised payment. Congress established the Board to give providers the right to an administrative hearing to assure accuracy in their payments prior to ultimate judicial review. Recognizing that the 180-day filing timeframe is nonjurisdictional is the only viable mechanism for enforcing a much-needed

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powers by ensuring that jurisdictional line-drawing, with all of its severe consequences, is left entirely in the hands of the Legislative Branch.

institutional check on agency missteps, knowing miscalculations, and other serious errors that the Secretary's own concealment otherwise would ensure could not be challenged within the 180-day window.

3. Finally, it bears noting that, for nearly four decades, the Secretary has treated Section 1395*oo*(a)(3)'s time limit as nonjurisdictional. 42 C.F.R. § 405.1841(b). If the Secretary were wrong, or if this Court's announced presumption that filing deadlines are nonjurisdictional were incorrect here, Congress has had forty years to change that. But it has not, even though it often addressed or referenced Section 1395*oo*. Just as congressional acquiescence supported according jurisdictional status to notices of appeal and suits in the Court of Claims, *see Bowles*, 551 U.S. at 210; *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 139 (2008), Congress's longstanding acceptance of (a)(3)'s nonjurisdictional status merits equal respect.

II. THE 180-DAY STATUTORY FILING DEADLINE IS SUBJECT TO EQUITABLE TOLLING.

The government agrees that Section 1395*oo*(a)(3)'s filing window is not jurisdictional (SG Br. 47), and does not dispute that the statutory text that Congress enacted is fully amenable to the presumptively available and evenhanded rule of equitable tolling traditionally applied by courts to statutory timeframes. The government, instead, argues for a one-way ratchet under which the Secretary singlehandedly sets the rules for tolling of challenges to her own decisions so that she can eternally revisit and recalculate overpayments based on provider misfeasance, but providers have no such

recourse against agency mispayments knowingly made and knowingly concealed.

That newly minted rule of inequitable tolling contravenes statutory text and purpose, and falls beyond the regulatory authority delegated by Congress. As the United States has argued, "[t]his Court has long held as a matter of equity that a defendant cannot use his own misconduct as a defense, including by unfairly relying on a statute of limitations." U.S. Br. in Opp. 8, *Gabelli v. SEC*, No. 11-1274 (cert. granted Sept. 25, 2012) (citing, *inter alia*, *Holmberg v. Armbrecht*, 327 U.S. 392, 397 (1946); *Bailey v. Glover*, 88 U.S. (21 Wall.) 342, 348-349 (1874)). That same rule applies here, when the government is the defendant.

A. All Statutory Filing Deadlines Are Presumptively Subject To Equitable Tolling.

"It is hornbook law that limitations periods are customarily subject to equitable tolling, unless tolling would be inconsistent with the text of the relevant statute." *Young v. United States*, 535 U.S. 43, 49 (2002) (internal quotation marks and citations omitted). That traditional understanding of limitations periods is so deeply embedded in the law that "Congress must be presumed to draft limitations periods in light of this background principle." *Id.* at 49-50.

Importantly, that "same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States." *Irwin v. Department of Veteran Affairs*, 498 U.S. 89, 95-96 (1990). "[M]aking the rule of equitable tolling applicable to suits against

the Government *** is likely to be a realistic assessment of legislative intent." *Id.* at 95.

Accordingly, the starting point in statutory construction is that Congress itself intended any limitations periods in a federal statute, including that in Section 1395*oo*(a)(3), to be "subject to a 'rebuttable presumption' in *favor* 'of equitable tolling.'" *Holland v. Florida*, 130 S. Ct. 2549, 2560 (2010) (quoting *Irwin*, 498 U.S. at 95-96).

B. The Statutory Text And Purpose Confirm That The 180-Day Limitations Period Is Subject To Equitable Tolling.

By all relevant indications, the presumption holds true in this case because Congress intended equitable tolling to apply to the filing period for Board review. There certainly is no "good reason to believe that Congress did *not* want the equitable tolling doctrine to apply." *Brockamp*, 519 U.S. at 350.

1. The statutory text confirms, rather than rebuts, the presumption of equitable tolling. *First*, the filing deadline's terms are straightforward and simple, virtually identical to the language in other provisions that this Court has recognized are subject to equitable tolling. *See, e.g.*, *Irwin*, 498 U.S. at 96 (tolling applies to provision for suit to be filed "[w]ithin 30 days of receipt of notice of final [EEOC] action," 42 U.S.C. § 2000e-16(c)); *Zipes*, 455 U.S. at 394-395 (tolling applies to provision that charge "shall be filed within [then 90 and now 180] days after the alleged unlawful employment practice occurred," 42 U.S.C. § 2000e-5(e)(1)).

Second, Section 1395*oo*(a) generally speaks in flexible, rather than the "unusually emphatic" terms

that might bar equitable tolling, *Brockamp*, 519 U.S. at 350. The statute specifies how a provider "may obtain" a hearing, 42 U.S.C. § 1395*oo*(a), and then the "fairly simple" language of the time limit (*Brockamp*, 519 U.S. at 350) requires only that the "provider file[] a request for a hearing within 180 days after notice of the intermediary's final determination," 42 U.S.C. § 1395*oo*(a)(3).

Completely absent from (a)(3)—and its surrounding text—are the type of rigid words of insistence, such as "must," "shall," or "in no event," that can weigh against tolling. *See Brockamp*, 519 U.S. at 351 (refund claim "shall be filed" within three years; "[n]o credit or refund shall be allowed" if claim is not timely filed) (quoting 26 U.S.C. §§ 6511(a) & (b)(1), respectively); *Becton Dickinson & Co. v. Wolckenhauer*, 215 F.3d 340, 350 (3d Cir. 2000) ("the emphatic, non-permissive nature of [26 U.S.C. § 7426(a)(1)] *** suggests that the time limitation at issue cannot be equitably tolled"). Thus, "linguistically speaking," the text at issue here can "easily be read as containing implicit exceptions." *Brockamp*, 519 U.S. at 350-351.[11]

Third, the filing-period language in (a)(3) is largely self-contained. Unlike the time for filing a tax refund claim at issue in *Brockamp*, Congress did not "reiterate[] its limitations several times in several different ways," 519 U.S. at 351, across the

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[11] Of course, mandatory language alone is not enough. *See, e.g., Burnett v. New York Cent. R.R. Co.*, 380 U.S. 424, 426 (1965) (applying equitable tolling to statute that said "'no action shall be maintained *** unless commenced within three years from the day the cause of action accrued'") (quoting 45 U.S.C. § 56 (1958)).

Medicare statute generally or the reimbursement process in particular. Tolling thus will not wreak "linguistic havoc" on the rest of the statute or "topple" a "detailed Jenga tower of deadlines and exceptions." Pet. App. 10a.

In addition, tolling would impose no "substantive limitation[]" on how a provider's reimbursement is calculated, *Brockamp*, 519 U.S. at 351-352. *Contra* SG Br. 42 n.19. In *Brockamp*, the tax statute mandated different caps for refunds or credits, triggered by whether or not a claim was filed within the three-year filing period. *See* 519 U.S. at 351 (comparing 26 U.S.C. § 6511(b)(2)(A), with 26 U.S.C. § 6511(b)(2)(B)). Here, by contrast, the amount of the underlying reimbursement is *not* affected by when a provider seeks Board review under Section 1395*oo*(a)(3).

Elsewhere, 42 U.S.C. § 1395*oo*(f)(2) provides that interest on Board awards for which judicial review is sought begins to accrue "on the first day of the first month after the 180-day period as determined pursuant to subsection (a)(3)[.]" That too is fully compatible with equitable tolling because that interest trigger is "determined by" (*id.*) the filing date for Board review, and thus would shift in tandem with any equitably tolled time period. So long as the provider "uses reasonable care and diligence in attempting to learn the facts," the 180-day clock does not run while the provider did not know and could not have known of the concealed misconduct, 4 Charles Alan, Arthur R. Miller, Mary Kay Kane, & Richard L. Marcus, Federal Practice

and Procedure § 1056 (3d ed. 2012) (tolled time period "halts" until barrier to filing is removed).[12]

Fourth, the 180-day deadline is of routine length, rather than "unusually generous," like the 12-year statute of limitations for the Quiet Title Act, *see United States v. Beggerly*, 524 U.S. 38, 48 (1998). And Congress did not build into the statutory time limit its own equitable tolling language that would displace the background rule. Section 1395*oo*(a)(3) is thus unlike the Quiet Title Act, which already provided that the "statute of limitations will not begin to run until the plaintiff 'knew or should have known of the claim of the United States.'" *Id.* 49. Here, equitable tolling will simply give effect to the background legislative intent; it will not effectively supplant a different tolling provision that Congress itself already wrote into the law. *See also Lampf, Pleva, Lipkind, Prupis & Petigrow v. Gilbertson*, 501 U.S. 350, 363 (1991) (equitable tolling foreclosed because statute already contained a discovery rule).[13]

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[12] That reading of the interest provision also comports with the background rule that interest is not available against the sovereign, and thus that any waiver of sovereign immunity for such monetary relief (unlike procedural time limits) should be narrowly construed. *See Library of Congress v. Shaw*, 478 U.S. 310, 316 (1986).

[13] The need for certainty and finality in the time limits governing title to land reinforced the Court's judgment in *Beggerly*. 524 U.S. at 49. The absence of any similar need to woodenly terminate all prospects for review at the 180-day mark here is documented by the Secretary's allowance for her own perpetual reopening of overpayments arising from provider misconduct. And the long backlog, numbering in the thousands, of Board cases belies any asserted need for rapid

Finally, the type of claim asserted here is "analogous to a contract claim" and thus is of "a type familiar to private litigation" where equitable tolling routinely applies. Pet. App. 6a n.1; *see Irwin*, 498 U.S. at 95. Indeed, the Medicare scheme itself not uncommonly gives rise to private litigation over reimbursement claims. Private risk-bearing health plans, known as Medicare Advantage plans, are responsible for roughly 20% of all Medicare payments.[14] *See, e.g.*, *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555, 559-560 (5th Cir. 2004) (provider's breach of contract action against HMO relating to Medicare Advantage reimbursements); *Highlands Wellmont Health Network, Inc. v. John Deere Health Plan, Inc.*, 350 F.3d 568, 577 (6th Cir. 2003) (medical center operator and HMO litigation over breach of Medicare Advantage contract).[15]

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closure. *See* Michael Harty, Chairman, PRRB, *Presentation to American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues* (Mar. 29, 2012), *available at* http://www.healthlawyers.org/Events/Programs/Materials/Documents/MM12/papers/CC_harty_slides.pdf (over 5,500 appeals awaiting adjudication at the end of fiscal year 2011, excluding appeals filed in 2011).

[14] *See* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/ReportsTrustFunds/Downloads/TR2012.pdf.

[15] Analogous claims outside of Medicare are also commonplace. *See e.g., Baptist Physician Hosp. Org., Inc. v. Humana Military Healthcare Servs., Inc.*, 368 F.3d 894, 900-901 (6th Cir. 2004) (breach of contract action against contractor for underpaying hospital based on faulty interpretation of applicable federal regulations); *Adams v. Reliance Standard Life Ins. Co.*, 225 F.3d 1179, 1185-1186 (10th Cir. 2000) (breach of contract action against insurance provider for underpaying benefits).

2. The statutory structure and purpose likewise confirm the applicability of equitable tolling. To begin with, (a)(3)'s time period is inextricably intertwined with the availability of judicial review under the statute, 42 U.S.C. § 1395*oo*(f)(1), and that judicial review provision fits squarely within *Irwin*'s equitable tolling rule. *See Lloyd Noland Hosp. & Clinic v. Heckler*, 762 F.2d 1561, 1564-1565 (11th Cir. 1985); *cf. Weinberger*, 422 U.S. at 763-764 (finding (f)(1)'s counterpart in the Social Security Act to be waivable).

Here, Board review is part of the process for "channeling *** review through the agency," providing the agency an opportunity for self-correction before judicial resources are expended, *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 17 (1999). Parity in tolling principles at the administrative and judicial levels comports with that function, ensuring that the administrative review process fulfills its purpose of taking a first cut at the providers' claims, rather than operating as some kind of backdoor cut-off of the very judicial review (with equitable tolling) that Congress authorized. Accordingly, "the argument that failure to comply with [the precursor] administrative regulation is by itself an independent reason for dismissing this suit *** would be open to attack on lines similar to those we hold require tolling the statute of limitations." *Honda*, 386 U.S. at 493 n.8.

Perhaps most importantly, equitable tolling is vital to fulfilling the statutory purpose. Congress created the Board with the very aim of affording Medicare providers the opportunity to ensure that the Secretary properly paid for services already

rendered. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 248 (1972) (Congress created the Board to "prescribe in law a specific appeals procedure for disputed final settlements applying to reasonable cost determinations" to "assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items.").

Failure to apply equitable tolling even to instances, like the present, where the Secretary confounded that review process by knowingly withholding information about its own knowing miscalculations would mean that the *Secretary* could singlehandedly defeat the meaningful review of the *Secretary's decisions* that Congress legislated. It would turn Congress's central statutory purpose upside down to hold that Congress, in Section 1395*oo*, left only the fox to guard the henhouse.

C. *Irwin*'s Longstanding Rule Of Statutory Construction Applies Equally To Administrative Deadlines.

The government argues (Br. 16-30) that all that statutory analysis is beside the point because the time period at issue here is for administrative, rather than judicial, review. That makes little sense.

1. To begin with, this Court adopted the presumption that limitations periods are subject to equitable tolling in *Irwin* because, given the pervasive and longstanding treatment of such filing timeframes as subject to tolling across the law, the presumption is "a realistic assessment of legislative intent." 498 U.S. at 95. Yet nothing in the Solicitor

General's argument provides any basis for concluding that, for this purpose, Congress dichotomized the world into administrative and judicial review, with only the former subject to a distinctively harsh, non-tolling rule.

Nor does the government cite any history or tradition of administrative timelines consistently foreclosing equitable tolling upon which Congress might have drawn. Quite the opposite, administrative processes are traditionally *more* flexible and forgiving than judicial review. And equitable tolling by an agency adjudicator like the Board is the rule, not the exception.[16]

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[16] *See, e.g., Kirkendall v. Department of Army*, 479 F.3d 830, 842-843 (Fed. Cir. 2007) (en banc) (appeals to the Merit Systems Protection Board); *Albillo-De Leon v. Gonzalez*, 410 F.3d 1090, 1097 (9th Cir. 2005) (motions to reopen immigration removal proceedings); *School Dist. of City of Allentown v. Marshall*, 657 F.2d 16, 19 (3d Cir. 1981) (complaints to the Secretary of Labor under 15 U.S.C. § 2622(b)(1)); *Ajalla v. White*, 81 Fed. App'x 715, 719 (10th Cir. 2003) (appeals of agency decisions to the EEOC); *Ramirez v. Secretary, U.S. Dep't of Transp.*, 686 F.3d 1239, 1243 (11th Cir. 2012) (time limit for contacting an EEOC counselor prior to asserting a Title VII claim); *White v. Bentsen*, 31 F.3d 474, 475 (7th Cir. 1994) (appeals to the EEOC under 29 C.F.R. § 1613.233(a)); *Jackson v. Astrue*, 506 F.3d 1349 (11th Cir. 2007) (appeals of SSA Appeals Counsel decisions under 42 U.S.C. § 405(g)); *Iavorksi v. United States INS*, 232 F.3d 124, 129-130 (2d Cir. 2000) (Sotomayor, J.) (motions to reopen immigration removal proceedings with the Board of Immigration Appeals); *Hill v. Merit Sys. Protection Bd.*, No. 2012-3024, 2012 WL 1663002, at *2 (Fed. Cir. May 14, 2012) (complaints to the Secretary of Labor under 5 U.S.C. § 3330a(a)(1)(A)); *Von Eye v. United States*, 92 F.3d 681, 684 (8th Cir. 1996) (commencing exempted conversions of wetland farm areas under 7 C.F.R.

That, presumably, is why this Court unquestioningly applied equitable tolling principles equally to administrative review schemes. *Zipes*, 455 U.S. at 398; *Union Pac. R.R. Co. v. Sheehan*, 439 U.S. 89, 93 (1978) (National Railroad Adjustment Board was capable of considering whether former employee's claim against railroad company was subject to equitable tolling); *cf. Henderson*, 131 S. Ct. at 1206 n.4 (government did not dispute that equitable tolling would apply to the 120-day deadline for review in the Article I Veterans' Court if the provision was nonjurisdictional).

The applicability of equitable tolling, moreover, is fundamentally an inquiry into legislative intent. *See Brockamp*, 519 U.S. at 350; *see also* SG Br. 40. And the very same textual, structural, and legislative indicia of intent applied in a tolling analysis of Section 1395*oo*(f)'s judicial review provision under *Irwin* equally inform the construction of Section 1395*oo*(a)'s Board review provision.

Indeed, because administrative and judicial review operate in tandem here (as in many statutes), applying equitable tolling to both halves of that integrated process is particularly appropriate. Surely "[w]hat is true of the *statutory* time limit for filing suits is no less true of the *regulatory* time limit for invoking review by the [agency]," and there can be no "argument for treating a time limit in a

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§ 12.5(b)(5)(iii)); *cf. Henderson* 131 S. Ct. at 1206 n.4 (recognizing possibility of equitably tolling deadline to appeal Board of Veterans' Appeals decisions to the Article I Court of Appeals for Veterans Claims).

regulation," much less a statutory time limit for administrative review, "as 'jurisdictional' while time limits in statutes [for judicial review] are subject to waiver and estoppel." *White v. Bentsen*, 31 F.3d 474, 475 (7th Cir. 1994). Otherwise, the Secretary's ability to preclude meaningful review of its Medicare payment decisions by suppressing the key evidence of her own errors until the relevant time periods for administrative review have passed would, in turn, effectively nullify the judicial review process.

2. Because the relevant indicia of legislative intent require the evenhanded application of *Irwin*'s tolling presumption to this administrative process, the government invokes a variety of other arguments to try and turn equitable tolling in the administrative context into a heads-the-government-wins-tails-the-private-party-loses rule of government-favoring tolling. None of them work.

First, the government argues (Br. 38-39) that administrative processes are necessarily against the government and thus do not have direct private litigation equivalents. That, of course, all depends on what level of comparison one assumes Congress would have applied, given that Medicare was established "to provide a hospital insurance program for the aged," and thus Medicare reimbursement cases are akin to insurance disputes. S. Rep. No. 404, 89th Cong., 1st Sess. 2 (1965); *see Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 506 (1994) ("Established in 1965 *** Medicare is a federally funded health insurance program for the elderly and disabled.").

Beyond that, this Court has never required a precise private equivalent as a *sine qua non* for tolling time limits against the government. Quite

the opposite, "[b]ecause [the] many statutes that create claims for relief against the United States or its agencies apply only to Government defendants, *Irwin's* reasoning would be diminished were it instructive only in situations with a readily identifiable private-litigation equivalent." *Scarborough v. Principi*, 541 U.S. 401, 422 (2004); *see also Bowen v. City of New York*, 476 U.S. 467, 480-481 (1986) (equitable tolling for social security benefits claims); *Honda*, 386 U.S. at 400 (equitable tolling for compensation claims against the government under the Trading with the Enemy Act).

Moreover, in *Holland*, the Court concluded that the one-year statute of limitations on petitions for federal habeas relief by state prisoners is subject to equitable tolling, a context in which a private analogue is almost entirely absent. *See* 130 S. Ct. at 2560-2561. That presumption was reinforced by the tribunal's inherent flexibility, 130 S. Ct. at 2561, a factor that equally applies to administrative review. Congress, after all, endowed the Board with flexible powers that exceed even those of a court of equity, including, for example, the broad authority to reach out and decide issues not ruled on below, to define its own rules and procedures, and to admit evidence that would be inadmissible under the Federal Rules of Evidence. *See* 42 U.S.C. §§ 1395*oo*(d), 1395*oo*(e), 1395*oo*(c).

Second, the government emphasizes (Br. 38) *Irwin's* reference to "suits" against the government, 498 U.S. at 95. But that is all that *Irwin*'s facts presented, which makes the Court's language perfectly understandable. This Court's discussion of what types of statutory provisions *are* subject to equitable tolling cannot be twisted into a suggestion

that other types of claims *are not* equally subject to the presumption, particularly given that the relevant indicia of legislative intent work the same in both the administrative and judicial contexts.

In any event, the government's argument forgets that a "right to sue," refers merely to the vindication of legal rights, and does not circumscribe the forum in which such rights are to be asserted. *See Compucredit Corp. v. Greenwood*, 132 S. Ct. 665 (2012).

Third, the government argues (Br. 23-25) that the Board is not equipped to apply equitable tolling principles. But the government cannot mean what it says. The Board already routinely applies precisely such principles in applying the Secretary's good-cause exception to the 180-day rule. Just as the Board has evaluated for decades whether "good cause" or, under the current regulation, "extraordinary circumstances" exist for missing the 180-day deadline, 42 C.F.R. § 405.1836(b) (2011), the Board can equally determine, under settled equitable tolling principles, whether the provider "has been pursuing his rights diligently," and whether "some extraordinary circumstance stood in his way," *Pace v. DiGuglielmo*, 544 U.S. 408, 418 (2005). Indeed, the Board, can, and regularly does, engage in equitable inquiries. *See, e.g.*, *Medical Coll. of Georgia Hosp.*, PRRB Dec. No. 2010-D31, 2010 WL 4214223 (May 25, 2010), *aff'd*, 2010 WL 5570990 (HCFA Adm'r July 13, 2010) (applying equitable tolling principles to DSH adjustments); *Bradford Hosp.*, 108 F. Supp. 2d at 488 (reinstating decision of

the Board to grant equitable tolling of deadline to submit request for redetermination).[17]

In short, while the Secretary understandably prefers that the Board apply such equitable considerations only to the conduct of providers, and deny review in cases of agency misconduct, the Board's institutional *capacity* to undertake such "fact-intensive" inquiries (SG Br. 28 n.15) fully exists.[18]

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[17] *See also St. Vincent's Hosp. FY 1986 Outlier Grp.*, 2000 WL 1146583 (HCFA Adm'r Jan. 3, 2000) (reversing Board's decision to hear untimely appeal on showing of good cause); *Delaware State Hosp. v. Blue Cross and Blue Shield Assoc.*, PRRB Dec. No. 97-D59, 1997 WL 354724 (May 26, 1997) (applying equitable tolling principles under good-cause exception); *SKI 1987-1994 DSH SSI% Group*, PRRB Dec. No. 2009-D12, 2009 WL 981317 (Mar. 5, 2009) (applying equitable tolling and constructive notice to DSH adjustment claims); *New Hanover Reg'l Med. Ctr. & Psych. Unit*, PRRB Dec. No. 2003-D37, 2003 WL 21804275 (July 17, 2003) (analyzing provider diligence and applying excusable neglect principles); *Care Unit Hosp. v. Mutual of Omaha*, PRRB Dec. No. 95-D26, 1995 WL 933968 (Mar. 8, 1995) (granting good-cause exception based on legitimate confusion) (*rev'd* by HCFA on May 15, 1995 without published decision); *General Counsel on Fin. and Admin. of the United Methodist Church*, No. R-11-006 (CMS Adm'r June 5, 2012) (granting extension of time to submit reconciliation payment); *Independent Outlier Group II*, 1999 WL 649069 (HCFA Adm'r July 23, 1999) (reversing Board's decision to grant good-cause exception based on evidence of provider notice).

[18] The agency's decision as to whether or not to allow a Board hearing after the 180-day filing deadline has lapsed is a "final determination" subject to judicial review under 42 U.S.C. § 1395*oo*(f)(1). Here, the Secretary did not seek review of the ruling below that the Board's refusal to toll is a "final

Finally, if the Board truly were incapable of applying equitable tolling principles evenhandedly, then the proper recourse would be to allow providers to skip administrative review and go directly to district court with their claims (where equitable tolling would be fully available under *Irwin* principles) on the ground that administrative exhaustion would be futile. *Cf. Bowen v. City of New York*, 476 U.S. at 484 (failure to comply with *any* requisites of administrative appeal process, including those set by statute and regulation, did not deprive district court of jurisdiction where the agency maintained "a systemwide, unrevealed policy that was inconsistent in critically important ways with established regulations").

Rather than assume that Congress intended to bypass administrative review in this setting, which often just makes the work of judicial review more difficult, the better assumption is that Congress wished to preserve the efficiencies of administrative channeling and, to that end, intended for equitable tolling to apply to both the administrative and judicial stages of review.[19]

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determination" subject to judicial review. *See* Pet. Cert. Reply Br. at 11 n.4.

[19] The government also objects (Br. 45) that Medicare is a large government program. But it is certainly no bigger or more complex than Social Security, to which equitable tolling applies. *See Bowen v. City of New York*, 476 U.S. at 479; *see also* Social Security Administration, Social Security Benefit Payment Data, http://www.ssa.gov/OACT/ProgData/payment.html (last visited Oct. 16, 2012) (total benefit payments for FY 2011 were $719,515,000,000); Social Security Administration, Growth in number of Social Security beneficiaries, http://www.ssa.gov/oact/progdata/icpGraph.html (last visited

D. The Secretary's One-Way Tolling Rule Merits No Deference.

The government does not and cannot dispute that equitable tolling is available to some degree under Section 1395*oo*(a)(3) because its own regulations both create a limited, three-year good-cause exception for requesting a Board hearing, 20 C.F.R. § 405.493 (1973); *see* 42 C.F.R. § 405.1836(b) (2011), and allow the Secretary to reopen a Medicare payment determination or decision without any time limitation or any requirement of due diligence based on "fraud or similar fault" by a party, *id.* § 405.1885(b)(3) (2011). Notably, that regulatory ability to revisit claims after the 180-day timeframe for fraud or similar fault operates, in the Secretary's view, as a one-way ratchet. That is because, contrary to the view expressed when the reopening regulation was first promulgated, the Secretary now interprets the "party" whose fault can support reopening to exclude the Secretary, the agency, and the fiscal intermediary. Br. 7-8 n.5.[20]

Oct. 16, 2012) (55 million Social Security beneficiaries as of December 2011).

[20] *See* 39 Fed. Reg. at 34,515 (text of Section 405.1885(d) was modified in the final rule to permit reopening due to fraud or similar fault by "any party" in response to comments that the different language used in the proposed rule had implied that "fraud, as a basis for reopening a determination or decision, applied only unilaterally to providers"). It also contradicts the Secretary's own notice and comment recognition that CMS "is the real party of interest in any litigation involving the administration of the [Medicare] program." 42 C.F.R. § 421.5(b); *see also United States v. Erika, Inc.*, 456 U.S. 201, 205 n.4 (1982).

The Secretary argues, in other words, that congressional intent is no longer the proper touchstone for equitable tolling when administrative review is at stake and, instead, courts must defer to whatever equitable tolling rules the agency devises as long as they survive *Chevron* rationality review.[21] And that deference, the Secretary argues, extends to a one-way tolling rule that permits perpetual reopening when a provider is at fault, but not when the Secretary is at fault. That is wrong for five reasons.

First, the indispensable predicate for *Chevron* deference to agency regulations is statutory ambiguity. *See Smiley v. Citibank (South Dakota), N.A.*, 517 U.S. 735, 740-741 (1996). Importantly, that ambiguity must linger *after* traditional rules of statutory construction, including presumptions like the *Irwin* equitable tolling rule, are applied. *Regions Hosp. v. Shalala*, 522 U.S. 448, 457 (1998) ("If, by 'employing traditional tools of statutory construction,' [courts] determine that Congress' intent is clear, 'that is the end of the matter.'") (quoting *Chevron*, 467 U.S. at 842–843). "Those traditional tools of statutory construction include the familiar presumptions we employ." *Goncalves v. Reno*, 144 F.3d 110, 127 (1st Cir. 1998) (applying presumption against retroactivity at *Chevron* Step 1). *Accord Bowen v. Georgetown Univ. Hosp.* 488 U.S. 204, 208-209 (1988) (same); *Carcieri v. Salazar*, 129 S. Ct. 1058, 1068 (2009) (relying, in part, on presumption against implied repeal, to support plain language reading of statute).

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[21] *See Chevron, USA Inc. v. NRDC*, 467 U.S. 837 (1984).

Here, as discussed above, application of the presumption eliminates any ambiguity for the agency to interpret. While the government cites the absence of congressional specificity, Congress's silence *supports* the presumption of tolling because Congress has amended the statute repeatedly after *Irwin* was decided, including one specific amendment to Section 1395*oo*, yet did nothing to alter the text of Section 1395*oo*(a)(3) or otherwise disavow the established default rule that this simple, 180-day filing deadline is subject to equitable tolling.[22]

The statutory text thus leaves no room for the Secretary to deprive providers of the very opportunity for Board review that Congress created because agency regulations, no matter how strictly worded, "do not partake of legislation and cannot override Congress' presumed statutory intent about the applicability of equitable tolling under *Irwin*." *Bailey v. West*, 160 F.3d 1360, 1367 (Fed. Cir. 1998), *overruled by Henderson v. Shinseki*, 589 F.3d 1201 (Fed. Cir. 2009), *overruled by Henderson v. Shinseki*, 131 S. Ct. 1197 (2011).

Second, that rule against agency deference in this context comports with the parallel principle that "administrative agencies directed by Congress to adjudicate particular controversies," like courts, "may not decline to exercise" their assigned jurisdiction. *Union Pacific R.R. Co.* 130 S. Ct. at 590. Regulations thus may not circumscribe the opportunities for Board review that Congress

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[22] *See* Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, § 13503, 107 Stat. 312, 579 (1993)); *see also* note 7, *supra*.

conferred on providers, nor may an agency "refus[e] to adjudicate cases on the false premise that it lack[s] power to hear them." *Id.* at 599; *see also Union Pac. R. Co. v. Sheehan*, 439 U.S. 89, 93 (1978) (National Railroad Adjustment Board was capable of considering whether former employee's claim against railroad company was subject to equitable tolling). Just as "language in a regulation can[not] conjure up a private cause of action that has not been authorized by Congress," *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001), an agency's regulatory authority does not extend to refusing to hear the causes of action that Congress has assigned to it. "Agencies may play the sorcerer's apprentice but not the sorcerer himself." *Id.*[23]

Third, *Chevron* deference applies only to those matters that logically fall within a congressional delegation of agency authority to address, such as "interstitial matters" that arise in the course of a program's daily administration, rather than "major questions" concerning a law's operation. *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000) (quoting Stephen Breyer, *Judicial Review of Questions of Law and Policy*, 38 Admin. L. Rev. 363, 370 (1986)); *Carcieri*, 129 S. Ct. at 1069-1070 (Breyer, J., concurring) (since Congress "did not intend to delegate interpretative authority" no deference accorded to agency's interpretation of term "now").

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[23] This Court recently granted certiorari to address whether *Chevron* deference even applies to an agency's interpretation of its own jurisdictional limits. *See City of Arlington v. Federal Communications Commission*, No. 11-1545, cert. granted Oct. 5, 2012.

Because the central function of the Board review provisions is to allow providers to obtain review of agency payment errors, it would defy "common sense" to hold that Congress delegated to that same agency the power to procedurally regulate itself right back out of such review in whole or in part. *Brown*, 529 U.S. at 133. "[D]eference," in short, "is not abdication, and it requires [the Court] to accept only those agency interpretations that are reasonable in light of the principles of construction courts normally employ." *EEOC. v. Arabian American Oil Co.*, 499 U.S. 244, 260 (1991) (Scalia, J., concurring in part and concurring in the judgment) (superseded by statute on other grounds).

Fourth, if *Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council*, 435 U.S. 519 (1978), were the panacea the government claims, one would have expected the government to have invoked it at some point in this litigation earlier than its first, fleeting mention at the rehearing stage below. *See* U.S. Pet. for Reh'g. 11-12. The government's hesitant embrace of *Vermont Yankee* is understandable because the case is inapt. *Vermont Yankee* held only that the formal rulemaking procedures set forth in the Administrative Procedure Act, 5 U.S.C. § 553, were the "maximum procedural requirements which Congress was willing to have the courts impose upon agencies in conducting rulemaking procedures," 435 U.S. at 523-524. Accordingly, the agency could not be faulted, when engaging in formal rulemaking, for failure to utilize procedures *beyond* those contained in the APA. *Id.* at 549.

The Secretary stresses that, under *Vermont Yankee*, "agencies should be free to fashion their own

procedures." SG Br. 17 (quoting 435 U.S. at 543-444). But whatever flexibility in fashioning administrative procedures agencies might generally enjoy, this case does not ask an agency to do more than Congress has authorized or to act beyond its capabilities. The question presented here, instead, is whether an agency can use its regulatory authority to foreclose, through its own misfeasance, the meaningful administrative and judicial review of agency action that Congress intended. *Vermont Yankee* says nothing of relevance about that.

Furthermore, an equally strong tenet of administrative law is that agencies should operate "under *** the fundamentals of fair play," *FCC v. Pottsville Broadcasting Co.*, 309 U.S. 134, 143 (1940), given the substantial "interest of citizens in some minimum standard of decency, honor, and reliability in their dealings with their Government," *Heckler v. Community Health Servs.*, 467 U.S. 51, 60-61 (1984). Here, the agency's asserted authority to unilaterally repudiate, through a one-way tolling rule, its contractual and statutory obligations to providers solely by virtue of its own knowing concealment of known errors runs headlong into those background principles. The agency's "3-year absolute bar *** simply tips the scale too far in favor of [agency] wrongdoers." *Lampf*, 501 U.S. at 379 (Kennedy, J., dissenting).

Finally, the government worries (Br. 25-28) that allowing evenhanded equitable tolling for fraud or similar fault will open the floodgates to claims. But the Secretary forgets that, since the statute's inception, Section 1395*oo*(a)(3) has coexisted quite comfortably with the agency's ever-shrinking, three-year "good cause" exception to the 180-day limitation

period. *See Irwin*, 498 U.S. at 96 ("[P]rinciples of equitable tolling *** do not extend to *** garden variety claim[s] of excusable neglect."). And the only colorable provider claims likely to arise outside that three-year window are those caused by the agency's own misfeasance, and even then only for such misconduct that a reasonable provider could not have timely uncovered with due diligence. *See Holmberg*, 327 U.S. at, 396 (recognizing that equity does not lie unless plaintiff acts diligently). The frequency with which claims of such governmental misfeasance in Medicare compensation determinations arise is, of course, entirely within the Secretary's own control.[24]

The government appends to its brief a list of pending claims for proper payment that it says were filed outside of the 180-day timeframe because they arose from the same knowing government concealment of its known shorting of payments to numerous Medicare providers, and thus could be affected by the decision in this case. It is difficult to understand why the government thinks that documenting the extent to which the Executive Branch departed from Congress's direction to properly compensate providers here somehow establishes *Congress's* intent to leave innocent

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[24] Because it is not at issue in this case, the Court need not address here whether the Secretary's significant narrowing of the good-cause exception in 2008 was proper. *See* 42 C.F.R. § 405.1836 (2011).

providers—including State and local governments and non-profits—holding the bag.[25]

Perhaps the government means to imply some large intrusion on the federal fisc. But that gets it backwards. The question here is whether claims that seek only to collect those payments that Congress statutorily committed itself to paying and has already fully funded can be entertained. The point of sovereign immunity has never been to empower an Executive Branch agency to run out the clock on its own knowing and concealed refusals to pay properly the compensation that Congress told it to pay and set aside money to pay.

The government, after all, has not disputed that the money that the Hospitals seek here (or the providers in its appendix) is money that Congress (i) *intended* those providers to be paid based on services provided to Medicare beneficiaries, and (ii) provided to the Medicare Trust Fund for the purpose of making those payments. And the federal government entered into a commitment with the providers to compensate them on agreed-upon terms for the provision of medical services to Medicare patients. Board review of the providers' claims simply asks the federal government to uphold its end

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[25] This is not the only instance in which such concealed agency missteps have harmed providers. *See Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 204-207, 216 (D.C. Cir. 2011) (long-concealed errors with respect to budget neutrality calculations of the rural floor adjustment); *cf. Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 815 (D.C. Cir. 2001) (reversing denial of mandamus and ordering Secretary to correct erroneous DSH payments based on Secretary's admittedly flawed interpretation of the statute).

of the bargain and pay what it promised. *See Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189 (2012) ("[A]s long as Congress has appropriated sufficient legally unrestricted funds to pay the contracts at issue, the Government's promise to pay [is] binding" and the "United States are as much bound by their contracts as are individuals.") (internal quotation marks omitted).

The government, with its appendix, forgets, in other words, that there are two sides to every story and that, if a *Baystate* type error occurred in each of those cases as alleged, then each of its cited cases represents providers who held up their end of the Medicare bargain only to have the Secretary secretly break Congress's payment promise and hide that fact. That does nothing to prove that Congress intended to allow the Secretary to insulate her misconduct from administrative and (consequently) judicial review anytime the agency manages to conceal its errors until the clock runs out. Whatever role Congress wished Section 1395*oo*(a)(3)'s timeframe to perform, "the [180]-day rule can hardly be deemed a device for augmenting" the Medicare Trust "fund at the expense of recognized creditors." *Honda*, 386 U.S. at 498.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted.

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ADDENDUM

ADDENDUM

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United States Code

Title 42. The Public Health and Welfare

Chapter 7. Social Security

Subchapter XVIII. Health Insurance for Aged and Disabled

Part E. Miscellaneous Provisions

§ 1395*oo*. Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the

amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each

provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent

with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpoenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a

hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant

to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5 governing appointments in the

competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

United States Code

Title 42. The Public Health and Welfare

Chapter 7. Social Security

Subchapter XVIII. Health Insurance for Aged and Disabled

Part E. Miscellaneous Provisions

§ 1395cc. Agreements with providers of services; enrollment processes

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement –

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title,

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of subchapter XI of this chapter as may be necessary

(i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A of this subchapter, and (I) shall be paid directly by the Secretary to such organization on behalf of

such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement organization (which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A of this subchapter but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H)(i) in the case of hospitals which provide services for which payment may be made under this

subchapter and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services--

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this subchapter,

to have items and services (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the skilled nursing facility,

(I) in the case of a hospital or critical access hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of Title 10, or under section 1713[1] of Title 38, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of Title 10,

(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c-3(a)(2) of this title by reason of a determination under section

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[1] See References in Text note below.

1320c-3(a)(1)(B) of this title,

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under section 1703 of Title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A of this subchapter (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as

the Secretary may specify,

(N) in the case of hospitals and critical access hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1395u(h)(4) of this title) for the area served by the hospital or critical access hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1395dd of this title with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under subchapter XIX of this chapter,

(O) to accept as payment in full for services that are covered under this subchapter and are furnished to any individual enrolled with a Medicare+Choice

organization under part C of this subchapter, with a PACE provider under section 1395eee or 1396u-4 of this title, or with an eligible organization with a risk-sharing contract under section 1395mm of this title, under section 1395mm(i)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b-1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this subchapter (less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this subchapter who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1395x(m)(5) of this title), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) of this section (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care

clearinghouse (as defined in section 1320d of this title) that meets each standard and implementation specification adopted or established under part C of subchapter XI of this chapter on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1395x(ee)(2)(H)(ii) of this title, or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1395ww(d)(12) of this title to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 1603 of Title 25), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 1603),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,[2]

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 [29 U.S.C.A. 651 et seq.] (or a State occupational safety and health plan that is approved under 18(b)[3] of such Act [29 U.S.C.A. 667(b)]), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated), and

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[2] So in original. The comma probably should be preceded by a closing parenthesis.

[3] So in original. Probably should be preceded by "section".

(W)[4] in the case of a hospital described in section 1395ww(d)(1)(B)(v) of this title, to report quality data to the Secretary in accordance with subsection (k).

(W)[4] maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this subchapter, as specified by the Secretary.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI of this chapter is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395*l*(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of

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[4] So in original. Two subpars. (W) have been enacted.

the amount customarily charged for such items and services by such provider) for which payment is made under part B of this subchapter or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1395*l*(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10)(A) of this title, and with respect to clinical diagnostic laboratory tests for which payment is made under part B of this subchapter. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395*l*(b) of this title and 20 percent of the payment basis described in section 1395m(a)(1)(B) of this title. In the case of items and services for which payment is made under part B of this subchapter under the prospective payment system established under section 1395*l*(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395*l*(t)(5) of this title. In the case of services described in section 1395*l*(a)(8) of this title or section 1395*l*(a)(9) of this title for which

payment is made under part B of this subchapter under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent

quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1320c-3(a)(4)(A) of this title and under section 1320c-3(a)(14) of this title with respect to services, furnished by the hospital, critical access hospital, facility, or agency involved, for which payment may

be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, facility, or agency in providing covered services under this subchapter and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of subchapter XI of this chapter.

United States Code

Title 42. The Public Health and Welfare

Chapter 7. Social Security

Subchapter XVIII. Health Insurance for Aged and Disabled

Part E. Miscellaneous Provisions

§ 1395ww. Payments to hospitals for inpatient hospital services

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(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

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(5)(F)(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such

hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI of this chapter.

1973 Code of Federal Regulations

Title 20. Employees' Benefits

Chapter III. Social Security Administration, Department of Health, Education, and Welfare

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged

Subpart D. Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Appeals by Provider

§ 405.493. Failure to timely request a hearing on a notice of program reimbursement determination.

Where a provider requests a hearing on a notice of amount of program reimbursement determination after the time limit prescribed in § 405.492(a), the designated individual(s) of the intermediary responsible for the hearing procedure shall dismiss the request and furnish the provider a written notice which explains the time limitation, except that for good cause shown the time limit prescribed in § 405.492(a) may be extended. However, no such extension shall be granted if such request is filed more than 3 years after the date of the notice of program reimbursement.

1974 Code of Federal Regulations

Title 20. Employees' Benefits

Chapter III. Social Security Administration, Department of Health, Education, and Welfare

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1841. Time, place, form, and content of request for board hearing.

(a) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination of the amount of program reimbursement was mailed to the provider or, where notice of such determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(b). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and

furnish any documentary evidence in support thereof. (b) A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date of the notice of the intermediary's determination is mailed to the provider.

2007 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged and Disabled

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1803. Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

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(2) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system

(see part 412 of this chapter), the intermediary must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by the hospital during the cost reporting period covered by the notice.

2007 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged and Disabled

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1841. Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in §405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's

determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see §413.17 of this chapter) must be brought by the providers as a group appeal (see §405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or CMS Rulings common to the providers and for which the amount in controversy is $50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

2007 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged and Disabled

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1885. Reopening an intermediary determination or reviewing entity decision.

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of

notice of the intermediary determination. No such determination or decision may be reopened after such 3–year period except as provided in paragraphs (d) and (e) of this section.

(b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3–year period specified in paragraph (a) of this section, CMS –

(i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and

(ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.

(2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

(3) Notwithstanding paragraph (b)(1)(i) of this section, CMS may direct the intermediary to reopen a particular intermediary determination or intermediary hearing decision in order to implement, for the same intermediary determination or intermediary decision –

(i) A final agency decision under §§ 405.1833, 405.1871(b), 405.1875, or 405.1877(a) of this part;

(ii) A final nonappealable court judgment; or

(iii) An agreement to settle an administrative appeal or a lawsuit.

(c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.

(e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

(f) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c).) However, the 3–year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27,

1972 (the effective date of regulations which, prior to the publication of this Subpart R, governed the reopening of such determinations).

2007 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 421. Medicare Contracting

Subpart A. Scope, Definitions, and General Provisions

§ 421.5. General provisions.

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(b) *Indemnification of intermediaries and carriers.* Intermediaries and carriers act on behalf of CMS in carrying out certain administrative responsibilities that the law imposes. Accordingly, their agreements and contracts contain clauses providing for indemnification with respect to actions taken on behalf of CMS and CMS is the real party of interest in any litigation involving the administration of the program.

2011 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged and Disabled

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1836. Good cause extension of time limit for requesting a Board hearing.

(a) A request for a Board hearing that the Board receives after the applicable 180–day time limit prescribed in § 405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

(b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180–day limit

specified in § 405.1835(a)(3).

(c) The Board may not grant a request for an extension under this section if –

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the Board must give prompt written notice to the provider, and mail a copy of the notice to each party to the appeal. The notice must include a detailed explanation of the reasons for the decision by the Board and the facts underlying the decision.

(e)(1) If the Board denies an extension request and determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Board dismissal decision dismissing the appeal for lack of Board jurisdiction. This decision by the Board must be in writing and include the explanation of the extension request denial required under paragraph (d) of this section, in addition to specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal (as described in § 405.1840(c) of this subpart). A copy of the Board's dismissal decision must be mailed promptly to each party to the appeal

(as described in § 405.1843 of this subpart).

(2) A Board dismissal decision under paragraph (e)(1) of this section is final and binding on the parties, unless the decision is reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) This Board decision is inoperative during the 60–day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision, within the period.

(ii) A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened and revised by the Board in accordance with § 405.1885 through § 405.1889 of this subpart.

(3) The Administrator may review a Board decision granting an extension request solely during the course of an Administrator review of one of the Board decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2) of this subpart.

(4) A finding by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time for requesting a Board hearing is not subject to judicial review.

2011 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged and Disabled

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1839. Amount in controversy.

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(b) Group appeals.

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(2) Aggregation of claims.

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(ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

2011 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 405. Federal Health Insurance for the Aged and Disabled

Subpart R. Provider Reimbursement Determinations and Appeals

§ 405.1885. Reopening an intermediary determination or reviewing entity decision.

(a) General.

(1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

(2) A determination or decision may be reopened either through own motion of CMS (for Secretary determinations), the intermediary or reviewing entity, by notifying the parties to the determination or decision (as specified in

§ 405.1887), or by granting the request of the provider affected by the determination or decision.

(3) An intermediary's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.

(4) If CMS directs an intermediary to reopen a matter, reopening is considered an own motion reopening by the intermediary. A reopening may result in a revision of any matter at issue in the determination or decision.

(5) If a matter is reopened and a revised determination or decision is made, a revised determination or decision is appealable to the extent provided in § 405.1889 of this subpart.

(6) A determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision within the meaning of this subpart and is not subject to further administrative review or judicial review.

(b) Time limits.

(1) Own motion reopening of a determination not procured by fraud or similar fault. An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887 of this subpart) is mailed no later than 3 years after the date of the determination or decision that is the subject of the reopening. The date the notice is mailed is presumed to be the date indicated on the notice unless it is shown by a preponderance of the evidence that the notice was mailed on a later date.

(2) Request for reopening of a determination not

based on fraud or similar fault.

(i) A reopening made upon request is timely only if the request to reopen is received by CMS, the intermediary, or reviewing entity, as appropriate, no later than 3 years after the date of the determination or decision that is the subject of the requested reopening. The date of receipt by CMS, the intermediary, or the reviewing entity of the request to reopen is conclusively presumed to be the date of delivery by a nationally-recognized next-day courier, or the date stamped "Received" by CMS, the intermediary or the reviewing entity (where a nationally-recognized next-day courier is not employed), unless it is shown by clear and convincing evidence that CMS, the intermediary, or the reviewing entity received the request on an earlier date.

(ii) A request to reopen does not toll the time in which to appeal an otherwise appealable determination or decision.

(iii) A request to reopen that is received within the 3–year period described in this paragraph is timely, notwithstanding that the notice of reopening required under § 405.1887 of this subpart is issued after such 3–year period.

(3) Reopening of a determination procured by fraud or similar fault. A Secretary or intermediary determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

(c) Jurisdiction for reopening. Jurisdiction for reopening an intermediary determination or intermediary hearing decision rests exclusively with the intermediary or intermediary hearing officer(s) that rendered the determination or decision (or, when applicable, with the successor intermediary), subject to a directive from CMS to reopen or not reopen the determination or decision. Jurisdiction for reopening a Secretary determination, CMS reviewing official decision, a Board decision, or an Administrator decision rests exclusively with CMS, the CMS reviewing official, Board or Administrator, respectively.

(1) CMS–directed reopenings. CMS may direct an intermediary or intermediary hearing officer(s) to reopen and revise any matter, subject to the time limits specified in paragraph (b) of this section, and subject to the limitation expressed in paragraph (c)(2) of this section, by providing explicit direction to the intermediary or intermediary hearing officer(s) to reopen and revise.

(i) Examples. An intermediary determination or intermediary hearing decision must be reopened and revised if CMS provides explicit notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by

the intermediary. CMS may also direct the intermediary to reopen a particular intermediary determination or decision in order to implement a final agency decision (as described in § 405.1833, § 405.1871(b) and § 405.1875 of this subpart), a final, non-appealable court judgment § 405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

(ii) [Reserved]

(2) Prohibited reopenings. A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS, whether made in response to judicial precedent or otherwise, is not a basis for reopening a CMS or intermediary determination, an intermediary hearing decision, a CMS reviewing official decision, a Board decision, or an Administrator decision, under this section.

(3) Reopening by CMS or intermediary of determination currently on appeal to the Board or Administrator. CMS or an intermediary may reopen, on its own motion or on request of the provider(s), a Secretary or intermediary determination that is currently pending on appeal before the Board or Administrator.

(i) The scope of the reopening may include any matter covered by the determination, including those specific matters that are appealed to the Board or the Administrator.

(ii) The intermediary must send a copy of the notice required under § 405.1887(a) to the Board or to the Administrator, through the Office of the Attorney Advisor, specifically informing that the matter(s) to be addressed by the reopening is currently under appeal to the Board or to the Administrator or is covered by the same determination that is under appeal.

(4) Reopening of determination within the time for appealing that determination to the Board. CMS or an intermediary may reopen, on its own motion or on request of the provider(s), a Secretary or intermediary determination for which no appeal was taken to the Board, but for which the time to appeal to the Board has not yet expired, by sending the notice specified in § 405.1887(a) of this subpart.

39 Fed. Reg. 8166, 8170 (Mar. 4, 1974)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social Security Administration

[20 C.F.R. Part 405]

Subpart R – Provider Reimbursement Determinations and Appeals

[Regulations No. 5]

FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Provider Reimbursement Review Board and Provider Appeals

Notice is hereby given, pursuant to the Administrative Procedure Act (5 U.S.C. 553), that the amendments to the regulations set forth below in tentative form are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. The proposed amendments (1) create a new Subpart R, entitled "Provider Reimbursement Determinations and Appeals," to implement the provisions of section 1878 of the Social Security Act, 42 U.S.C. 1395oo, as added by section 243 of the Social Security Amendments of 1972, P.L. 92-603, which established a Provider Reimbursement Review Board independent of the jurisdiction of the Social Security Administration and its fiscal intermediaries; and (2) relocate the substance of §§ 405.490 through 405.499i of Subpart D of Regulations No. 5 in the new Subpart R to provide for an orderly structure of regulations applicable to providers' appeals of cost

reimbursement determinations and decisions under the Federal Health Insurance for the Aged program. It is intended that the proposed amendments to Regulations No. 5, with respect to the Provider Reimbursement Review Board, be effective for the cost reporting periods ending on or after June 30, 1973. (See § 405.1801(c) (2).)

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[39 Fed. Reg. 8170]

§ 405.1885 Reopening a determination or decision.

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such officer, Board, or Secretary, as the case may be, either on motion of such officer, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such reopening must be undertaken within 3 years of the date of the notice of the intermediary or Board hearing or decision, or when there has been no such decision, any such reopening must be undertaken within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

*****

(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or

hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of the provider.

39 Fed. Reg. 34,514 (Sept. 26, 1974)

Title 20 – Employees' Benefits

CHAPTER III – SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[Regs. No. 5, amended]

PART 405 – FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Provider Reimbursement Determinations and Appeals

On March 4, 1974, there was published in the FEDERAL REGISTER (39 FR 8166) a notice of proposed rule making with proposed amendments to Subparts D and R of Regulations No. 5 (20 CFR Part 405), implementing section 243 of Pub. L. 92-603 (86 Stat. 1386-89) entitled "Provider Reimbursement Review Board." Interested persons were given 30 days within which to submit written comments or suggestions thereon. Comments and suggestions were received from various organizations, institutions, and individuals interested in health services. All the comments have been considered and the proposed regulations are herby adopted with the following significant changes:

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6. Section 405.1885(d) of the regulations was modified to provide for reopening a determination or decision at any time it is established that said determination or decision was procured by fraud or similar fault of any party. Several who commented suggested that the language as proposed in §

405.1885(d) implied that fraud, as a basis for reopening a determination or decision, applied only unilaterally to providers.

51 Fed. Reg. 31,454, 31,459 (Sept. 3, 1986)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

42 C.F.R. Parts 405 and 412

[BERC-353-F]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: We are amending the Medicare regulations governing the inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system.

In addition, we are describing changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. In general, these changes are applicable to discharges occurring on or after October 1, 1986. We are also setting forth the update factors for determining the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

EFFECTIVE DATE: This final rule is effective on October 1, 1986. We refer the reader to section VI.A. of this preamble for a discussion of specific provisions that apply to specific periods.

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[51 Fed. Reg. 31,459]

Comment: We received several comments objecting to the fact that we are requiring hospitals to bear the expense of having their SSI/Medicare percentage recomputed for their own cost reporting period. These commenters pointed out that the law requires us to make the disproportionate patient percentage determination on a cost reporting period basis and therefore, that HCFA, not the hospital, should bear the cost if the hospital wishes to have its SSI/Medicare percentage recomputed based on its own cost reporting period.

Response: We recognize that the law specifies that the SSI/Medicare percentage be determined for each hospital on a cost reporting period basis. However, in the interim final rule we proposed matching SSI eligibility records to the Medicare bills on a Federal fiscal year basis because we believe this is the most efficient approach.

The data sources for computation of the SSI/Medicare percentage include the Medicare inpatient discharge file which is compiled on a Federal fiscal year basis and includes approximately 11 million billing records (this compilation is done about three or four months after the close of the federal fiscal year and is then updated periodically as additional discharge data are received) and the SSI file that lists all SSI recipients for a 3-year period and denotes the months during that period in which the recipient was eligible for SSI benefits. (The SSI file includes over 5 million records.) In order to compute the SSI/Medicare percentage, the 11 million

records from the discharge file must be individually matched by beneficiary number and month of hospitalization, with the SSI recipient records. On a Federal fiscal year basis, this match would be performed on a yearly basis. If done on a cost reporting period basis the match would have to be done on a flow basis. Because of the volatility of the SSI enrollment/disenrollment process and the billing lags, it would be necessary to set up an extensive, expensive on-going system that would require monthly submissions of eligibility records from the Social Security Administration to be used to annotate the Health Insurance Master File or a new SSI master file. This master file would have to contain individual periods of entitlement, since SSI eligibles may be enrolled and disenrolled on a month by month basis. These files would have to be matched to every inpatient billing record (approximately 1 million a month) and that billing record annotated by the number of covered days associated with a period of enrollment.

*****

Also, since the Medicare billing data does not indicate a hospital's cost reporting period, another match with the latest cost report file would be required to determine a hospital's cost reporting period. However, since cost reporting periods are subject to change, and HCFA Central Office does not know whether a hospital has changed cost reporting periods until its cost report is received through HCRIS, we would not assure the accuracy of this determination. Another reporting system would have to be established to ensure that we are computing the SSI/Medicare percentage for the appropriate period.

Given the extensive amount of processing involved in computing the SSI/Medicare percentage by cost reporting period as well as the fact that we cannot guarantee timeliness and accuracy, we believe we are justified in making this determination on a Federal fiscal year basis.

Recognizing the difficulty hospitals would have identifying their Medicare patients who are also SSI recipients, we have undertaken the task (and expense) of determining for each hospital the number of patient days of those dually entitled to Medicare Part A and SSI and have removed this burden from the hospitals.

52 Fed. Reg. 33,034, 33,047 (Sept. 1, 1987)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 C.F.R. Parts 405, 412, 413, and 466

[BERC-400-F]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS

ACTION: Final rule.

SUMMARY: We are revising the Medicare inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system. One of these changes is the inclusion of the prospective payment system of hospitals located in Puerto Rico.

In addition, in the addendum to this rule, we describe changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. In general, these changes are applicable to discharges occurring on or after October 1, 1987. We also set forth the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system.

EFFECTIVE DATE: This final rule is effective on October 1, 1987. We refer the reader to section VII.A. of this preamble for a discussion of specific provisions

that apply to specific periods.

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B. Summary of the Provisions of the June 10, 1987 Proposed Rule

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• We discussed several current provisions of the regulations in 42 CFR Parts 405, 412, 413, and 466 and set forth certain proposed changes concerning—

— Review of DRG assignments ***.

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[52 Fed. Reg. 33,047]

We will continue to monitor the processing of hospital requests for DRG adjustment to determine whether the omissions and errors made by coding personnel justifies additional training efforts by the ICD-9-CM Coordination and Maintenance Committee. Although the processing of these bills by fiscal intermediaries will continue to have a lower priority than initial payment processing and coordination, we will monitor the number of these requests to determine if there is a substantial adverse impact of the procedure on the overall Medicare payment to any one hospital or any group of hospitals and make any necessary adjustments.

A hospital that receives an unfavorable decision on its request for review of DRG assignment may appeal that decision under the provisions of 42 CFR Part 405, Subpart R.

60 Fed. Reg. 45,778, 45,812 (Sept. 1, 1995)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 C.F.R. Parts 412, 413, 424, 485, and 489

[BPD-825-FC]

RIN 0938-AG95

Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 1996 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In addition, in the addendum to this final rule, we are describing changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. These charges are applicable to discharges occurring on or after October 1, 1995. We are also setting forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are setting forth several requirements concerning Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals

(RPCHs), in accordance with provisions of the Social Security Act Amendments of 1994.

DATES: *Effective Date:* This final rule is effective on October 1, 1995, except that revised § 412.46 (concerning the physician attestation requirement for inpatient claims) is effective September 1, 1995.

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[60 Fed. Reg. 45,812]

Comment: We received three comments, all of which supported our proposal to use the MedPAR file data to recalculate Medicare Part A/SSI percentages rather than continuing the requirement that hospitals submit a tape of their Medicare Part A data based on their cost reporting periods. However, one commenter was concerned that HCFA provide an opportunity for hospitals to verify the data ***.

Response: Since there was no opposition to the proposed change, we are adopting it in this final rule. Because the SSI data used in the calculation are protected by the Privacy Act, we cannot provide an opportunity for hospitals to verify these data. The data that the Social Security Administration (SSA) uses to determine the Medicare Part A/SSI percentage are not released to HCFA and therefore we are unable to produce these data for hospitals. We must accept the data that are officially collected and compiled by the SSA on a monthly basis. The SSA is responsible for administering the SSI program and keeps track, on a monthly basis, of those individuals who receive SSI benefits.

REPLY BRIEF

No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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In the Supreme Court of the United States

No. 11-1231

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONER

Since the creation of the Provider Reimbursement Review Board, the Secretary of Health and Human Services has prohibited the Board from extending the 180-day administrative appeal deadline in 42 U.S.C. 1395*oo*(a)(3), except as provided by regulation. For nearly 40 years, the applicable regulation has permitted an extension only for good cause shown and only if the request is filed within three years of the intermediary's Notice of Program Reimbursement (NPR). 42 C.F.R. 405.1841(b); 42 C.F.R. 405.1836 (2011).[1] And for the same 40 years, the Secretary has offered providers an opportunity to correct errors in the NPR of the sort respondents allege here (and recover underpayments) through a motion to reopen that likewise must be filed

[1] Unless otherwise indicated, all references to Title 42 of the C.F.R. are to the 2007 version.

within three years. 42 C.F.R. 405.1885(a); 42 C.F.R. 405.1885(b) (2011). Under well-settled principles of administrative law, the Court should sustain this established statutory and regulatory framework and reject respondents' proposed open-ended equitable tolling regime. Such a regime would undo the repose those time limits afford and fundamentally alter the administrative appeals process that has governed Medicare provider payments from the beginning and thereby maintained order and finality in an exceedingly complex regulatory scheme.

Respondents contend that the Medicare Act itself requires equitable tolling and, thus, adherence to the framework established by the Secretary is not warranted. But the statutory text does not even mention tolling; rather, respondents rely solely on a presumption in favor of equitable tolling that has no application here. Without that thumb on the scale, the Secretary's considered judgment and reasonable regulations are controlling. And even with a presumption, the Secretary's judgment and reasonable regulations remain sound: equitable tolling has no place in the complex and technical world of Medicare provider payments. In the end, respondents fail to establish that the Secretary's regulations are arbitrary, capricious, or contrary to Section 1395*oo*(a)(3) of the Medicare Act.

ARGUMENT

A. Respondents Mischaracterize The Facts Of This Case And The Secretary's Regulatory Regime

Respondents tell a story of agency "misfeasance" involving the "knowing concealment of known errors" that has deprived them of money "promised" by Congress. Br. 3, 18, 20, 31, 32, 33, 34, 55, 56, 58. In respondents' view, such agency "misconduct" is protected by a regu-

latory regime that they say operates as a "one-way tolling rule," allowing "perpetual reopening when a provider is at fault, but not when the Secretary is at fault." Br. 18, 19, 38, 39 n.13, 48, 50, 51, 55, 56, 58. Notwithstanding the number of times respondents retell that story, it is wrong.

1. Respondents' charges of "misfeasance" arise from administrative and judicial proceedings brought by Baystate Medical Center (Baystate). Baystate (unlike respondents here) timely appealed its disproportionate share hospital (DSH) adjustment determinations. The Board ultimately concluded that the information used by the Centers for Medicare & Medicaid Services (CMS) to calculate the SSI fraction was not "the best available data" and that there were flaws in the data-matching process. *Baystate Med. Ctr.*, PRRB Dec. No. 2006-D20, 2006 WL 752453, at *33-*34 (Mar. 17, 2006); see *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, 26-31, amended in part, 587 F. Supp. 2d 37 (D.D.C. 2008) (*Baystate*).[2] The Administrator reversed in relevant part, concluding that the Board was wrong to require CMS to achieve "an errorless match" in computing the SSI fraction and that, even using the provider's sample, only "approximately 1.59 percent of the individuals failed to match" and thus the provider failed to demonstrate that its reimbursement was adversely affected by

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[2] CMS calculates the SSI fraction because it "[r]ecogniz[ed] the difficulty hospitals would have identifying their Medicare patients who are also SSI recipients." 51 Fed. Reg. 31,459 (1986). To "remove[] this burden from hospitals," CMS decided to "undertake[] the task (and expense) of determining for each hospital the number of patient days of those dually entitled to Medicare Part A and SSI." *Ibid.*; cf. 60 Fed. Reg. 45,812 (1995) ("Because the SSI data used in the calculation are protected by the Privacy Act, we cannot provide an opportunity for hospitals to verify these data.").

the asserted errors. *Baystate*, 2006 WL 1684639, at *26, *35 (May 11, 2006). The district court in turn reversed in part, holding that CMS had not used "the best available data" to calculate the SSI fraction. *Baystate*, 545 F. Supp. 2d at 40-50. Specifically, the court concluded that CMS should have but did not use the most up-to-date SSA data in its possession, *id.* at 42-43, and that the data used omitted certain types of records that SSA could have included, *id.* at 44-46.

Contrary to respondents' allegations, no administrative or judicial tribunal has ever found that CMS "affirmative[ly] conceal[ed] known errors." Br. 19. Indeed, the district court and the Board both found precisely the opposite. The district judge in this case, who was also the district judge in *Baystate*, stated unequivocally that "nothing in either [the Board's or the district court's] *Baystate* decisions reflects a finding that CMS 'deliberately concealed' the data flaws at issue or otherwise engaged in fraud." Pet. App. 44a. The court explained that, in *Baystate*, the Board simply "rejected the contention that CMS had used the 'best available data,'" and the *Baystate* court reached the same conclusion. *Ibid.* The Board has similarly made clear that "[t]he decisions in *Baystate* did not result in a finding of fraud." *Medical Coll. of Ga. Hosp.*, PRRB Dec. No. 2010-D30, 2010 WL 4214223, at *4 (May 25, 2010), aff'd, 2010 WL 5570990 (CMS Adm'r July 13, 2010). The administrative and judicial findings that CMS failed to use the best available data to calculate the SSI fraction bear little resemblance to the "knowing[] and systematic[]" effort to underpay providers that respondents seek to portray. Br. 3.[3]

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[3] After the district court's decision in *Baystate*, the Secretary revised the matching process for all Medicare providers through notice-

Respondents' related suggestion that CMS is able to "conceal its errors until the clock runs out" (Br. 58) ignores a critical fact: respondents were in the same position as the hospital in *Baystate*. In 1999, Baystate timely challenged the intermediary's calculation of its DSH adjustments and "mounted diligent efforts" to obtain records from CMS and SSA. *Baystate*, 545 F. Supp. 2d at 51; A.R. at 8767-8768, *Baystate, supra* (No. 1:06-cv-1263) (11/19/99 Letter from Baystate to PRRB). The *Baystate* proceedings were paid for by a healthcare consulting firm that represents hundreds of other DSH hospitals and that negotiated a 35% contingency fee to prosecute *Baystate*. Southwest Consulting Assocs. Amicus Br. 1-3, 19 (Southwest Amicus Br.); *Baystate*, 545 F. Supp. 2d at 34 n.22. Beginning in 1993, the consulting firm began looking into what it believed were errors in CMS's calculation of the SSI fraction and ultimately "advise[d] Baystate to question the agency's SSI calculations." Southwest Amicus Br. 9-10. Although that same consulting firm now suggests that "[t]he Board's 2006 decision in *Baystate* really was the earliest clue to the regulated community that they *might* have been underpaid as a result of flaws in CMS's calculation of the SSI fraction," *id.* at 20, that firm and its clients necessarily had a "clue" many years prior.[4] And Baystate was

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and-comment rulemaking, 75 Fed. Reg. 50,275-50,286 (2010), and the Administrator directed that the revised matching process be applied to every "properly pending DSH appeal of the SSI fraction data matching process issue," HHS, CMS Ruling 1498-R, at 6, Apr. 28, 2010, http://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/CMS1498R.pdf.

[4] Many of the purported "facts" set forth by Southwest represent a disputed interpretation of the record in *Baystate* and not the findings by any administrative or judicial tribunal. See Gov't Mot. for Summ. J. at 29-44, *Baystate*, *supra* (No. 1:06-cv-1263) (explaining the alleged

not the first hospital to challenge the SSI fraction. In 1993, another hospital timely appealed seeking recalculation of its DSH adjustments based on its own independent calculation of the SSI fraction. See *Loma Linda Cmty. Hosp.* v. *Shalala*, 907 F. Supp. 1399, 1400-1402 (C.D. Cal. 1995).

Respondents, in contrast, allowed the statutory and regulatory deadlines to expire, and sat on the sidelines during seven years of administrative proceedings in *Baystate*. Only when that test case proved successful did respondents file piggyback appeals, more than a decade late.[5] The ease with which respondents (and nearly 200 other hospitals, Gov't Br. App. 34a-37a) now assert "fraud" and proclaim ignorance only further demonstrates why an equitable-tolling regime previously unknown to the Medicare provider appeals process would prove highly disruptive and burdensome. See *United States* v. *Brockamp*, 519 U.S. 347, 352 (1997);

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data errors and CMS's response and refuting "Baystate's contentions that agency employees repeatedly lied about the DSH calculations").

[5] The hospital provider community was well aware of issues regarding the SSI calculation throughout the pendency of the *Baystate* proceedings. See, *e.g.*, *Saint Mary's Mercy Med. Ctr.*, PRRB Dec. No. 2007-D63, 2007 WL 3341598, at *2 (Aug. 24, 2007) (in 2000, provider "undertook a review" of its SSI fraction "after questions arose in the hospital reimbursement community"); *St. Joseph Mercy Hosp.*, 2010 WL 5571062, at *3-*4 (CMS Adm'r Oct. 6, 2010) (provider challenged SSI calculation no later than March 2001 and appeal was placed in abeyance pending *Baystate*); John R. Jacob, *Hospitals Want Bigger Piece of Medicare Pie*, Nat'l L.J. (Aug. 30, 2004) ("hospitals have long believed that [SSI] percentages were improperly low" and "growing number of cases" pending before Board on that issue).

High Country Home Health, Inc. v. *Thompson*, 359 F.3d 1307, 1311 (10th Cir. 2004).[6]

2. Respondents repeatedly describe the regulatory regime, first adopted in 1974, as a "one-way ratchet" or a "one-way tolling rule." Br. 34, 50, 51, 55. Contrary to respondents' contention, however, the limited opportunities for additional administrative review after the expiration of 180 days are largely neutral.

The good-cause regulation, allowing limited extensions of the appeal deadline, inures only to the benefit of providers. The reopening regulation, for its part, is largely neutral. 42 C.F.R. 405.1885(a) (allowing reopening "on motion" of the intermediary, the Board, the Secretary, or the provider). Reopening may remedy underpayments or result in the recovery of overpayments. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 455-456 (1999) (*Your Home*). And while providers cannot seek discretionary reopening after three years, neither can the intermediary, the Board, or the Secretary. 42 C.F.R. 405.1885(a) ("No such determination or decision may be reopened after such 3-year period"); 42 C.F.R. 405.1885(b) (requiring reopening in certain circumstances if "within the 3-year period"). Thus, an intermediary determination or Board decision could not be reopened under the regulations after three years if the Secretary discovered that errors in calculating the SSI fraction had *overstated* hospitals' DSH payments. The opportunity for a hospital to seek an extension for taking an appeal for good cause, or to seek reopening, within three years is a manifestation of the Secretary's

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[6] Approximately 80% of the hospitals paid under the Prospective Payment System (PPS) receive DSH payments. See 77 Fed. Reg. 53,721-53,724 (2012) (3423 PPS hospitals, including 1903 urban and 820 rural DSH hospitals).

"grace," *Your Home*, 525 U.S. at 454, not a one-way ratchet—particularly not one that favors the Secretary.

The only example of the purported inequity that respondents identify is 42 C.F.R. 405.1885(d), which requires reopening "at any time if it is established that [the] determination or decision was procured by fraud or similar fault of any party to the determination or decision." The so-called "fraud" exception to the absolute three-year deadline for reopening is limited in scope and rarely used. CMS has taken the position that the term "established" requires an independent administrative or judicial finding of fraud or similar fault separate from any reopening, such as in a False Claims Act case. See, *e.g.*, Gov't Mot. to Dismiss or Summ. J. at 22, *Bradley Mem'l Hosp.* v. *Thompson*, 1:04-cv-416 Docket entry (D.D.C. July 30, 2004). A regulatory regime that allows the agency to recover overpayments in those circumstances based on fraud should not "shock[]" this Court, which was willing to countenance "a system in which underpayments could *never* be the basis for reopening." *Your Home*, 525 U.S. at 455.[7]

3. Respondents' insistence that somehow Congress promised them the payments they seek in this litigation, no matter how long after the fact, is equally unfounded. *E.g.*, Br. 57-58. When a provider chooses to participate in the Medicare program, its payments depend on the Medicare Act and the Secretary's implementing regulations, which require providers to comply with specified procedures in order to receive payment. A provider that

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[7] Contrary to respondents' contention (Br. 10, 50), the fraud exception applies equally to a fiscal intermediary if it "procured" a Board decision by "fraud or similar fault." A fiscal intermediary is a "part[y]" to the Board hearing, 42 C.F.R. 405.1843(a), even though it is not a "part[y]" to its own determination, 42 C.F.R. 405.1805.

fails to comply with those procedures is not entitled to payment any more than a taxpayer who fails to seek a refund within a specified period of time. Respondents' characterization of the payments allegedly due as "fully funded" and "set aside" by Congress, *id.* at 57, when the suit is based on cost reports that have been closed for a decade or more, blinks reality. Congress did not promise or set aside money to pay Medicare providers in 2012 for services rendered in 1987 in a case not appealed until 2006.

B. Respondents' Arguments For Ignoring Well-Established Principles of Administrative Law Are Unpersuasive

Respondents do not dispute that, through notice-and-comment rulemaking contemporaneous with the enactment of Section 1395*oo*(a)(3) nearly 40 years ago, the Secretary determined that the Board has no authority to hear appeals filed beyond the 180-day deadline, except as provided by regulation—*i.e.*, for good cause shown *if* the request is filed within three years of the NPR. Respondents also do not dispute that an equitable-tolling regime would conflict with the limitations in the Secretary's regulations. Respondents nevertheless contend that settled principles of administrative law precluding courts from imposing extra-statutory procedural requirements on an administrative tribunal, see *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978) (*Vermont Yankee*), and from setting aside a duly promulgated regulation that is neither arbitrary nor capricious, should not apply here. Respondents fail to confront the force of this Court's precedents.

1. The government's opening brief argues at length (Br. 17-29) that *Vermont Yankee* prohibits courts from unilaterally imposing on agencies additional procedural rules not required by statute, and that the equitable-

tolling regime adopted by the court of appeals here would do precisely that. Respondents devote three paragraphs to arguing that *Vermont Yankee* is "inapt." Br. 54-55. Contrary to respondents' suggestion, *Vermont Yankee* is not limited to an agency's rulemaking procedures, nor to an analysis of the procedures imposed by the Administrative Procedure Act (APA). See *Pension Benefit Guar. Corp.* v. *LTV Corp.*, 496 U.S. 633, 653-656 (1990) (applying *Vermont Yankee* to informal agency adjudication where no provision in governing statute or APA afforded asserted procedural rights). Rather, as this Court explained in *Vermont Yankee*, "[e]ven apart from the [APA] this Court has for more than four decades emphasized that the formulation of procedures was basically to be left within the discretion of the agencies to which Congress had confided the responsibility for substantive judgments." 435 U.S. at 524; see *FCC* v. *Pottsville Broad. Co.*, 309 U.S. 134, 143 (1940).

2. Respondents make no attempt to argue that the Secretary's good-cause regulation for an extension of the appeal deadline, including the three-year outer limit, is arbitrary or capricious. Gov't Br. 29-31. Neither do respondents dispute that the good-cause regulation falls squarely within the Secretary's broad rulemaking authority. *Id.* at 18. Respondents do contend (Br. 54) that Congress would not have delegated authority to the Secretary to avoid performing administrative review required by Congress, but the substance of respondents' objection is not clear. If they are suggesting that the Secretary has no authority to interpret the Board's adjudicatory jurisdiction, the Court held otherwise in *Your Home*. Gov't Br. 50-51; *id.* at 49-50 (citing cases). If they are merely suggesting that the Secretary has no authority to reject open-ended equitable tolling because

in their view Congress mandated it, their nondelegation argument collapses into a question of statutory interpretation. See Part C, *infra*. On its face, Section 1395*oo*(a)(3) provides for Board review only "*if*," among other things, the provider files a hearing request within 180 days. 42 U.S.C. 1395*oo*(a)(3) (emphasis added). If there were any conflict between the good-cause regulation and the plain language of the statute, it would be with the Secretary's allowance of *any* extension of the 180-day period, not her failure to adopt an amorphous equitable-tolling regime that has had no place in the Medicare provider payment program for the entire history of its existence. See Court-Appointed Amicus Br. 41-47.

C. Congress Did Not Mandate Open-Ended Equitable Tolling Of The 180-Day Appeal Period

Respondents argue that *Chevron* deference is not warranted because Section 1395*oo*(a)(3) is not ambiguous. Br. 51-52. That argument rests not on the statutory text, which says nothing about equitable tolling, or on generally applicable tools of statutory interpretation. Instead, respondents rely exclusively on the presumption in favor of equitable tolling that this Court adopted in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), for a statute of limitations applicable to suits filed in court. See Br. 52 ("[A]pplication of the presumption eliminates any ambiguity for the agency to interpret."). No such presumption applies here. But even if a presumption applied in some form, the Secretary's implementation of Section 1395*oo*(a)(3) is sound and respondents cannot prevail.

1. a. This Court has never applied the *Irwin* presumption to impose equitable tolling on internal agency review procedures. Gov't Br. 32-36. Neither case cited

by respondents (Br. 44) applied a presumption and each is inapposite for other reasons. The government's opening brief (Br. 33-34) explains in detail why *Zipes* v. *Trans World Airlines, Inc.*, 455 U.S. 385 (1982), is readily distinguishable. *Union Pacific R.R.* v. *Sheehan*, 439 U.S. 89, 92 (1978) (per curiam), is even further removed because the Court did nothing more than explain that, as a matter of fact, the National Railroad Adjustment Board *had* considered the railroad employee's claim that the applicable time deadline (in a collective-bargaining agreement) should be equitably tolled.

Respondents contend that it would "make[] little sense" to forgo a "statutory analysis" where "the time period at issue" is "for administrative, rather than judicial, review." Br. 42. That misapprehends the government's argument. If Congress intends a statutory time limit to be subject to equitable tolling, that intent of course controls. Before its decision in *Irwin*, the Court used traditional tools of statutory interpretation to determine whether equitable tolling of a suit-filing time limit implicating the Federal Treasury would be "consistent with Congress' intent," *Bowen* v. *City of N.Y.*, 476 U.S. 467, 480 (1986). Gov't Br. 40-41. In the administrative context, traditional tools of statutory construction entail application of the rules governing judicial review of an agency action or interpretation, which are drawn from the APA, *Chevron*, and *Vermont Yankee*. Where Congress has expressly granted authority to an agency to promulgate rules and procedures to govern the administrative appeals process, it makes "little sense" (Resp. Br. 42) to *presume* that Congress intended the Judiciary to adopt freestanding equitable exceptions to statutory and regulatory deadlines and other prerequisites to internal administrative review. Far

from "a realistic assessment of legislative intent," *id.* at 42 (quoting *Irwin*, 498 U.S. at 95), incantation of a presumption would redistribute the authority granted by Congress from the expert agency to the courts. See *Pottsville Broad.*, 309 U.S. at 144 (cautioning against reading "the laws of Congress through the distorting lenses of inapplicable legal doctrine"); *id.* at 141 ("[T]o the extent that a federal court is authorized to review an administrative act, there is superimposed upon the enforcement of legislative policy through administrative control a different process from that out of which the administrative action under review ensued.").

For these reasons, respondents' assertion that "equitable tolling by an agency adjudicator" is "the rule, not the exception," Br. 43, proves very little. There are many instances in which the administering agency *agrees* that equitable tolling should be available, or that some other exception to finality should be allowed, at least in certain circumstances. Indeed, here, the Secretary has done so by adopting the regulations allowing reopening and extension of the appeal deadline, subject to the three-year limitation. There may also be instances in which the administering agency has declined to allow equitable tolling, but a contrary congressional intent is clear. A presumption in favor of equitable tolling is not needed to identify those cases.[8]

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[8] The courts of appeals cases cited by respondents (Br. 43 n.16) are distinguishable. *Jackson* v. *Astrue*, 506 F.3d 1349, 1352-1353 (11th Cir. 2007), did not involve an administrative deadline, but rather the same judicial review deadline at issue in *City of New York*. In several other cases, the administering agency agreed that equitable tolling was available. *Hill* v. *Merit Sys. Prot. Bd.*, No. 2012-3024, 2012 WL 1663002, at *3 (Fed. Cir. May 14, 2012) (discussing equitable tolling of administrative complaint deadline which government conceded was available in prior case, see *Kirkendall* v. *Department of Army*, 479

b. To the extent respondents argue that this Court can apply *Irwin*'s presumption without identifying a "precise private equivalent," Resp. Br. 45-46, the government does not disagree, Gov't Br. 38. But respondents' reliance on *Holland* v. *Florida*, 130 S. Ct. 2549, 2560-2562 (2010), to suggest that they need not identify *any* private analogue is misplaced. As the government explains in its opening brief (Br. 39 & n.18), *Holland*, a state habeas corpus case, did not require the Court to identify any private analogue because habeas (quite unlike statutory payments under Medicare) has historically been governed by equitable principles, and because *Holland* was not a suit against the United States, let alone one implicating the heightened sovereign-immunity principles that govern when a party seeks money from the Federal Treasury. Respondents also cite *City of New York*, 476 U.S. at 480, and *Honda* v. *Clark*, 386 U.S. 484, 500-501 (1967), but *Honda* did not

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F.3d 830, 837 (Fed. Cir.) (en banc), cert. denied, 552 U.S. 948 (2007)); *Ajalla* v. *White*, 81 Fed. Appx. 715, 719 (10th Cir. 2003) (29 C.F.R. 1614.604(c) expressly provides for equitable tolling of regulatory deadline); *Von Eye* v. *United States*, 92 F.3d 681, 684 (8th Cir. 1996); *White* v. *Bentsen*, 31 F.3d 474, 475 (7th Cir. 1994), cert. denied, 514 U.S. 1050 (1995); *School Dist. of Allentown* v. *Marshall*, 657 F.2d 16, 18-19 (3d Cir. 1981); cf. *Ramirez* v. *Secretary*, 686 F.3d 1239, 1243 (11th Cir. 2012) (regulation provides for mandatory extension in specified circumstances). In one case where the government argued that equitable tolling was unavailable, the defendant agency did not ask for deference in the court of appeals. *Kirkendall*, 479 F.3d at 836-844 (veterans discrimination appeal). The other two cases involved time limits for motions to reopen immigration removal proceedings. *Albillo-De Leon* v. *Gonzales*, 410 F.3d 1090, 1095-1098 (9th Cir. 2005); *Iavorski* v. *INS*, 232 F.3d 124, 129-134 (2d Cir. 2000) (Sotomayor, J.). The reopening statutes and regulations there, however, have been read by some courts to suggest flexibility, *e.g.*, *id.* at 130-132, and removal proceedings do not involve sophisticated institutional litigants.

involve payments from the general Treasury, and both decisions predated *Irwin* and therefore looked to congressional intent without applying any presumption in favor of equitable tolling.

c. If a presumption in favor of equitable tolling were to apply at all in this context, it would be substantially weakened because equitable principles have not traditionally governed Medicare provider payments, and because the 180-day administrative appeal period was enacted 18 years before this Court's decision in *Irwin*. Gov't Br. 39-40. Respondents' answer is to describe the Board's powers as "flexible." Br. 46. But the only "flexibility" respondents point to is expressly set forth by statute; the Board does not have any inherent equitable powers outside those prescribed by the Medicare Act and the Secretary's implementing regulations. Gov't Br. 20-22.

2. Even if the *Irwin* presumption had some application, there are "good reason[s] to believe that Congress did *not* want the equitable tolling doctrine to apply[.]" *Brockamp*, 519 U.S. at 350.

a. For nearly 40 years, the Secretary has prohibited the Board from extending the 180-day deadline, except as provided by regulation. Until the decision below, no court had ever superimposed equitable-tolling principles onto that statutory and regulatory scheme. Against that backdrop, Congress amended Section 1395*oo* on six separate occasions and never expressed any disapproval of the Secretary's interpretation. Gov't Br. 20 & n.8. "It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the 'congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended

by Congress.'" *CFTC* v. *Schor*, 478 U.S. 833, 845-846 (1986) (citation omitted).

Respondents do not dispute any of this history. Indeed, they rely on it to argue that the 180-day administrative appeal deadline is not jurisdictional. Resp. Br. 17-18, 34. According to respondents, "for nearly four decades, the Secretary has treated Section 1395*oo*(a)(3)'s time limit as nonjurisdictional" and "Congress's longstanding acceptance of (a)(3)'s nonjurisdictional status merits * * * respect." Br. 34.[9] It is true that the Secretary has not treated Section 1395*oo*(a)(3)'s time limit itself as "jurisdictional" in the sense that she could not allow for any extension by regulation. But from the outset the Secretary has imposed strict limitations on such extensions. Congress's longstanding acceptance of the Secretary's treatment of Section 1395*oo*(a)(3) thus necessarily includes acceptance of those strict limitations, which are incompatible with the equitable tolling respondents seek.

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[9] Respondents contend that "for nearly forty years, most courts and the Executive Branch's published regulations have treated" the 180-day limit "as nonjurisdictional and subject to equitable exceptions." Br. 23 n.6. That is incorrect. First, two of the three courts of appeals to consider the issue concluded that the time limit *is* jurisdictional in the strictest sense and that even the Secretary's regulation allowing extensions for good cause is invalid. Compare *St. Joseph's Hosp.* v. *Heckler*, 786 F.2d 848, 851-853 (8th Cir. 1986), and *Alacare Home Health Servs., Inc.* v. *Sullivan*, 891 F.2d 850, 856 (11th Cir. 1990), with *Western Med. Enters.* v. *Heckler*, 783 F.2d 1376, 1379-1380 (9th Cir. 1986). Second, during that 40-year time frame, *no* court ever recognized an "equitable" exception to the statutory and regulatory appeal deadline. Third, the Secretary's "published regulations" likewise never recognized any "equitable" exceptions. See pp. 19-20, *infra*.

b. Nothing about the 60-day deadline set forth in 42 U.S.C. 1395*oo*(f)(1) for seeking *judicial* review suggests otherwise. Resp. Br. 41-42. Even assuming that time limit is subject to equitable tolling,[10] it does not follow that the administrative time limit for seeking Board review must also be subject to tolling that the Secretary's regulations do not allow. A provider is entitled to judicial review only if it has satisfied the statutory preconditions, which include securing a "final decision of the Board." 42 U.S.C. 1395*oo*(f)(1). As relevant here, a provider may obtain a hearing before the Board (and, thus, a final decision) only if "such provider" is dissatisfied with the intermediary's payment determination; the amount in controversy is $10,000 or more; and the request is filed within 180 days. 42 U.S.C. 1395*oo*(a). Pursuant to that statutory scheme, if the provider is not "dissatisfied," or if the amount in controversy is less than $10,000, the provider is not entitled to any judicial review of the intermediary's determination. The same is true of a provider who fails to file a hearing request within the period specified by Section 1395*oo*(a) and the Secretary's regulations.

There is another, more practical reason to distinguish the judicial review deadline in Section 1395*oo*(f)(1) from the administrative appeal deadline in Section

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[10] The Secretary has argued that the 60-day judicial review period in Section 1395*oo*(f)(1) is not subject to equitable exceptions. The courts have reached different conclusions. Compare *Lloyd Noland Hosp. & Clinic* v. *Heckler*, 762 F.2d 1561, 1564-1565 (11th Cir. 1985) (subject to waiver and equitable tolling), and *Bedford Cnty. Mem'l Hosp.* v. *Heckler*, 583 F. Supp. 367, 370-371 (W.D. Va. 1984) (subject to waiver), aff'd, 769 F.2d 1017 (4th Cir. 1985), with *Wilmac Corp.* v. *Thompson*, No. 03-5936, 2007 WL 2599238, at *2-*3 (E.D. Pa. Sept. 4, 2007) (not subject to equitable tolling), and *Kidney Ctr.* v. *Shalala*, 63 F. Supp. 2d 51, 55-57 (D.D.C. 1999) (not subject to waiver).

1395*oo*(a)(3). The universe of reasons for invoking equitable tolling of the 60-day judicial review deadline would be quite limited. Once a provider has "notice" that a final administrative decision has issued, 42 U.S.C. 1395*oo*(f)(1), it would be exceedingly difficult to assert a justification for missing the filing deadline, especially more than a few days or weeks. The limited case law touching on equitable tolling of the 60-day deadline, see note 10, *supra*, bears that out. By contrast, as amply demonstrated by this case and the other related cases pending in district court, Gov't Br. App. 34a-37a, the same cannot be said of the 180-day administrative appeal deadline. Superimposing an open-ended equitable tolling regime onto the carefully structured administrative review process would deprive closed payment determinations from many years earlier of the finality they have long enjoyed, and would place substantial administrative burdens on the agency, its contractors, and the Medicare Trust Fund, Gov't Br. 23-28, in a way that equitable tolling of the judicial review deadline would (and has) not. Even if Congress intended the latter, it would not have envisioned (let alone mandated) the former. Simply put, the program could not function with any degree of efficiency without the order and finality achieved through the statutory and regulatory regime that has long governed the administrative review process.

c. Respondents' attempts to minimize the importance of administrative finality and the practical effects of an equitable-tolling regime are unavailing.

Respondents first contend (Br. 47-48) that the Board is perfectly capable of engaging in a fact-intensive equitable tolling inquiry and, indeed, has been "regularly" engaging in "equitable inquiries." Respondents conflate the Secretary's focused good-cause regulation with the

open-ended equitable tolling regime they urge.[11] The good-cause regulation is substantially more limited than judicially imposed equitable tolling. Most significantly, like the reopening regulation, it has a mandatory three-year outer limit. Respondents barely acknowledge that critical distinction. There is a world of difference between the possibility that a past cost year may be revisited within three years of the intermediary's determination, but no later, and the possibility that a past cost year may be revisited *at any time*. Moreover, while equitable tolling is itself a narrow doctrine, it is still broader than the Secretary's limited good-cause exception to the 180-day appeal deadline—particularly after the 2008 regulatory amendments. 73 Fed. Reg. 30,206 (2008); 42 C.F.R. 405.1836(b) (2011) (limiting good cause to "extraordinary circumstances beyond [the hospital's] control (such as a natural or other catastrophe, fire, or

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[11] Only four of the cases respondents cite discuss equitable tolling. Two involved the same *Baystate* issue presented here. In those cases, the Board, after holding that equitable tolling is unavailable as a matter of law, briefly explained that, even if tolling were available, it would not be warranted based on the "undisputed facts." *Medical Coll. of Ga. Hosp.*, 2010 WL 4214223, at *3; *SKI 1987-1994 DSH SSI% Group*, PRRB Dec. No. 2009-D12, 2009 WL 981317, at *4 (Mar. 5, 2009). The other two cases did not involve the 180-day appeal deadline at issue here, and any analysis of equitable principles was cursory at best. See *Bradford Reg'l Med. Ctr.*, PRRB Dec. No. 99-D19, 1999 WL 10149, at *8 (Jan. 7, 1999) (90-day period for submitting supporting documentation relating to capital-related costs), rev'd, 1999 WL 398034 (HCFA Adm'r Mar. 12, 1999), rev'd, *Bradford Hosp.* v. *Shalala*, 136 F. Supp. 2d 428 (W.D. Pa. 2001); *New Hanover Reg'l Med. Ctr. & Psychiatric Unit*, PRRB Dec. No. 2003-D37, 2003 WL 21804275, at *6 (July 17, 2003) (180-day period for requesting adjustment to rate-of-increase ceiling). The equitable-tolling inquiry respondents advocate would in fact be a drastic departure from the Board's "regular[]" practice that has endured for nearly 40 years.

strike)"). Accordingly, application of the good-cause exception does not require the agency to devote significant resources to adjudicating untimely appeals. Gov't Br. 24.

Respondents also contend that no "floodgates" would open because equitable-tolling claims would be limited to "the agency's own misfeasance," which is "entirely within the Secretary's own control." Br. 55-56. That equitable-tolling relief should rarely be *granted*, however, does not mean that the doctrine would rarely be invoked. Recent history shows that what constitutes "misfeasance" is in the eye of the beholder. Gov't Br. 25-27. As this Court recognized in *Brockamp*, the mere availability of equitable tolling "could create serious administrative problems by forcing the [agency] to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for 'equitable tolling' which, upon close inspection, might turn out to lack sufficient equitable justification." 519 U.S. at 352; see *High Country*, 359 F.3d at 1311 ("[F]or every plaintiff whose substantive claim or reason for default leads an adjudicator to excuse the default, ten less sympathetic plaintiffs are likely to demand similar treatment.").

The Medicare Act's "complex and highly technical regulatory program" heightens the need for finality. *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (citation omitted); see *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1235 (D.C. Cir. 1994) ("policy of retroactive corrections would erode the predictability and finality that underlie the [Medicare Prospective Payment System] scheme"). This Court recognized in *Your Home* that "the statutory purpose of imposing a 180-day limit on the right to seek Board review of NPRs * * * would be frustrated by permitting requests to reopen to be re-

viewed indefinitely." 525 U.S. at 454. Engrafting an open-ended equitable tolling regime onto Section 1395*oo*(a)(3) would have an even more dramatic effect, because it would not be cabined by a three-year outer limit. Contrary to respondents' assertion (Br. 39 n.13), the need for order and finality under Medicare is especially critical in light of the backlog of cases before the Board. Gov't Br. 30-31. "[T]he Board is burdened by an immense caseload," and "procedural rules requiring timely filings are indispensible devices for keeping the machinery of the reimbursement appeals process running smoothly." *High Country*, 359 F.3d at 1310.[12]

D. The Board Has No Authority To Adjudicate Appeals Filed Outside The Statutory And Regulatory Deadlines

Respondents contend (Br. 34) that the government agrees that Section 1395*oo*(a)(3) is not jurisdictional. What the government explains in its opening brief, however, is that although Section 1395*oo*(a)(3) does limit the Board's jurisdiction, it does not preclude the Secretary from adopting a narrow and time-limited good cause exception to the 180-day filing deadline, in the exercise of her broad authority under the Medicare Act. Section

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[12] Respondents compare the size of the Medicare program to that of Social Security, Br. 49 n.19, but there are at least two critical distinctions. First, the disability benefits scheme at issue in *City of New York* was "designed to be 'unusually protective' of claimants," 476 U.S. at 480, whereas the Medicare payment scheme at issue here involves "sophisticated" institutional providers, *Your Home*, 525 U.S. at 456. Second, a determination of individual entitlement to disability benefits does not have the breadth and technical complexity involved in a determination of Medicare provider payments. In that respect, Medicare provider payments are more analogous to the subject matter in *Brockamp* (tax collection) than to the subject matter in *City of New York* (Social Security disability benefits).

1395*oo*(a)(3) and the regulations implementing it then *together* establish mandatory time limits on the Board's adjudicative authority. The court of appeals erred in overriding those mandatory limits by imposing an unprecedented open-ended equitable tolling regime on the Medicare provider appeals process that Congress enacted 40 years ago.

* * * * *

For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General

NOVEMBER 2012

REPLY BRIEF

No. 11-1231

IN THE
Supreme Court of the United States

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the District of Columbia Circuit

REPLY BRIEF FOR COURT-APPOINTED *AMICUS CURIAE* SUPPORTING REVERSAL

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IN THE
Supreme Court of the United States

No. 11-1231

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the District of Columbia Circuit

REPLY BRIEF FOR COURT-APPOINTED *AMICUS CURIAE* SUPPORTING REVERSAL

The explicit, precisely drawn, and unqualified timely filing requirements prescribed by 42 U.S.C. § 1395*oo*(a)(3) clearly constitute a jurisdictional limitation on the authority of the Provider Reimbursement Review Board ("PRRB" or "Board") to hear Medicare provider appeals. This conclusion rests on two basic premises derived from the Medicare Act itself: First, § 1395*oo*(a) uniquely defines the Board's authority to hear cases (*viz.* its jurisdiction); no other provision of the Medicare Act plausibly serves that purpose. Second, Congress granted the Secretary of Health and Human Services ("the Secretary") express administrative discretion to extend filing deadlines

for *beneficiary* appeals under the Medicare Act but omitted any such discretion for the deadlines governing Medicare *provider* appeals.

Respondents squarely deny the first proposition,[1] urging this Court (1) to focus on whether Congress used a jurisdictional "label," (2) to hold that a provision cannot be jurisdictional if it is framed in terms of the litigant's right to invoke the tribunal's authority, and (3) to adopt a *per se* test treating nearly all filing deadlines as claims-processing rules. *See* Resp. Br. 21-25. But these results find no support in this Court's precedents. Respondents—here, joined by petitioner—also reject the second proposition; they deny that Congress's contrasting approach to beneficiary and provider appeals has any bearing on legislative intent. *See* Pet. Br. 48-49; Resp. Br. 29 n.9. Their position contradicts this Court's well-settled approach to interpreting statutes, in general, and the Medicare Act, in particular. These errors cause respondents to take a one-dimensional view of this Court's precedents, equating § 1395*oo*(a)(3) with timely filing requirements that appear in remedial statutes lacking one or both of subsection (a)'s salient characteristics. *See* Resp. Br. 22-24.

Respondents and petitioner also offer a hodgepodge of arguments built on supposed legislative acquiescence in the Secretary's regulatory exception to § 1395*oo*(a)(3) (*see* Pet. Br. 43; Resp. Br. 34), on speculation about the general purposes of the Medi-

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[1] Petitioner has a more complicated position; she believes that § 1395*oo*(a) and her implementing regulations together impose a jurisdictional constraint on the Board's authority. *See* Pet. Br. 47. Petitioner's position, however, contradicts this Court's understanding of the nature of jurisdictional constraints. *See infra* pp. 17-18.

care Act (*see* Resp. Br. 30-34), and on the Secretary's asserted discretion to prescribe her own procedural rules, even when doing so deviates from subsection (a)(3)'s filing deadline (*see* Pet. Br. 47-48). These contentions are wrong, but even if they were right they could not displace the clear jurisdictional import of § 1395*oo*(a)(3)'s text and structure.

Finally, respondents seek to buttress their reading of subsection (a)(3)'s timely filing requirement by asserting that subsection (a)'s other threshold requirements—namely, the "dissatisfaction" and amount-in-controversy provisions—are themselves nonjurisdictional. Respondents' position finds no support in any decision of the Board, the Centers for Medicare & Medicaid Services ("CMS"), or the Secretary. More importantly, to the extent that respondents suggest that Congress gave the Board authority to hear cases that do not satisfy the carefully detailed threshold requirements for a Board hearing, their position represents an unlikely reconstruction of congressional intent.

1.a. The text of § 1395*oo*(a) clearly defines the Board's power to hear Medicare provider appeals, specifying the appropriate subject matter for a Board hearing, the requisite amount in controversy, and the time within which a provider appeal must be filed. *See* 42 U.S.C. § 1395*oo*(a)(1)-(3); *see also Amicus* Br. 18-24. Although respondents are correct that Congress did not affix a "jurisdictional" label to § 1395*oo*(a),[2] this Court has made clear that Con-

[2] The opening brief for Court-Appointed *Amicus* relied on the caption "Establishment" as evidence that Congress understood subsection (a) as a jurisdictional provision. *See Amicus* Br. 11, 19, 28. Respondents correctly note that the caption "Establishment" originated in the codifiers' revisions to §1395*oo*(a), rather

gress need not "use magic words in order to speak clearly" in establishing jurisdictional requirements. *Henderson v. Shinseki*, 131 S. Ct. 1197, 1203 (2011). Rather, what matters is that subsection (a) alone "delineat[es] the classes of cases" that the Board has authority to adjudicate—the defining characteristic of a jurisdictional provision. *Kontrick v. Ryan*, 540 U.S. 443, 455 (2004). In fact, if § 1395*oo*(a) does not define the Board's jurisdiction to adjudicate Medicare provider appeals, then no provision of the Medicare Act does.

Respondents nevertheless contend (at 23) that the timely filing requirement must be nonjurisdictional because Congress worded it in terms of the *provider's right* to a hearing, rather than in terms of the *Board's authority* as such. But respondents' conclusion does not follow from their premise. The right to invoke a tribunal's authority to hear a case is the mirror image of the tribunal's power to hear the case. Accordingly, in several recent cases, the Court has found procedural conditions on a party's right to sue to be jurisdictional. *See, e.g., Bowles v. Russell*, 551 U.S. 205, 213 (2007) (28 U.S.C. § 2107); *Miller-El v. Cockrell*, 537 U.S. 322, 336 (2003) (28 U.S.C. § 2253(c)(1)); *FEC v. NRA Political Victory Fund*, 513

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than in the enactment itself. *See* Resp. Br. 24-25 & n.7. At the same time, however, respondents err in further suggesting that Congress must label a provision "jurisdictional" in order to satisfy the Court's clear-statement rule. *See, e.g., id.* at 24 (stressing that "Congress nowhere labeled the timeframe as jurisdictional"). As this Court has made clear, the appropriate inquiry uses all of the relevant tools of statutory interpretation—text, context, structure, and purpose. *See Amicus* Br. 16. Here, those tools lead to the conclusion that Congress intended subsection (a) to be jurisdictional.

U.S. 88, 90 (1994) (28 U.S.C. § 2101(c)).[3] Congress's choice to phrase a provision in terms of the one rather than the other thus does not alter the reality that § 1395*oo*(a) uniquely specifies the scope of the Board's adjudicative authority.

Respondents further suggest that this Court has treated time limits as *categorically* nonjurisdictional except in those areas in which this Court's precedents establish "a long tradition" of treating such requirements as jurisdictional. *See* Resp. Br. 22-23 & n.6 (discussing *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 139 (2008); *Bowles*, 551 U.S. at 210-13). If that suggestion were true, this Court in *Henderson*, 131 S. Ct. at 1203, could simply have stopped its inquiry once it concluded that the time limit at issue there—as in this case, a deadline for appealing from one non-Article III tribunal to another—fell outside any long tradition establishing its jurisdictional status. But the Court did not stop there. Instead, before determining whether the time

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[3] Respondents cite (at 22) *Reed Elsevier, Inc. v. Muchnick*, 130 S. Ct. 1237 (2010), for the proposition that filing deadlines define the rights of the parties rather than the power of the tribunal. That characterization does not, however, fairly describe the Court's opinion, which relied on a variety of contextual factors to determine that the procedural requirement at issue—the obligation to register a copyright with the Copyright Office before filing suit—was nonjurisdictional. The Court emphasized that the registration requirement was "located in a provision 'separate' from those granting federal courts subject-matter jurisdiction over [copyright] claims." *Id.* at 1245-46. Noting that the registration requirement was subject to several important statutory exceptions, the Court added that it would be "at least unusual to ascribe jurisdictional significance to a condition subject to these sorts of exceptions." *Id.* at 1246. *Reed Elsevier*'s contextual analysis contradicts rather than supports the categorical approach that respondents press here.

limit was or was not jurisdictional, the Court found it necessary to examine carefully the text, context, structure, and purpose of the veterans' statute at issue in the case. *See id.* at 1205-06. In other words, this Court uses *all* the traditional tools of statutory interpretation to determine whether Congress expressed a clear intent to treat a timely filing requirement—or any other requirement—as jurisdictional.

b. Reading § 1395*oo*(a)(3) in light of the structure of the Medicare Act as a whole reveals a clear congressional intention to adopt a strict and unqualified filing requirement for Medicare providers. *See Amicus* Br. 31-40. In the 1972 legislation that established the PRRB review scheme for provider appeals, Congress incorporated by reference the Social Security Act's procedures for administrative appeals and judicial review of beneficiary claims. *Compare* Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1329, 1420 (provider appeals), *with id.* § 299O, 86 Stat. 1464-65 (beneficiary appeals). Of central importance here, while the provisions governing Medicare *providers* adopted unqualified deadlines for such providers to seek administrative and judicial review (*see* 42 U.S.C. § 1395*oo*(a)(3), (f) (Supp. II 1973)), the provisions incorporated by reference for Medicare *beneficiaries* gave the Secretary explicit administrative discretion to extend the analogous deadlines for such beneficiaries to seek administrative and judicial review (*see id.* § 1395ff(b) (Supp. II 1973) (incorporating by reference 42 U.S.C. § 405(b) and (g) (1970))).

Petitioner suggests that the contrasting approaches of the two sets of provisions tell us little because (1) the 1972 amendments merely reenacted beneficiary provisions that had originated in the Medicare

Act of 1965, and (2) the administrative discretion prescribed for Medicare beneficiary appeals was incorporated by reference from provisions of the Social Security Act that had been enacted many years before any of the Medicare legislation. *See* Pet. Br. 48-49. Even if Congress had adopted the two sets of contrasting provisions at different times in different pieces of legislation, it would *still* be appropriate for this Court to read § 1395*oo*(a)(3) "to contain that permissible meaning which fits most logically and comfortably into the body of both previously and subsequently enacted law." *West Virginia Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 100 (1991).[4] In any event, neither of petitioner's contentions alters the reality that, in a single piece of legislation, Congress plainly adopted one strategy for *beneficiary* appeals (explicit administrative discretion) and another for *provider* appeals (no such discretion).

For their part, respondents merely argue (at 29 n.9) that "the nonjurisdictional character of (a)(3) is reinforced, not metamorphosized, by the existence of another *nonjurisdictional* provision . . . that . . . specifically permits regulatory exceptions to a statutory deadline for Medicare beneficiary claims." But this Court has made clear that, "'when the legislature uses certain language in one part of the statute and different language in another, the court assumes different meanings were intended.'" *Sosa v. Alvarez-Machain*, 542 U.S. 692, 711 n.9 (2004) (quoting 2A NORMAN J. SINGER, STATUTES AND STATUTORY

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[4] This Court employs such an approach "not because that precise accommodative meaning is what the lawmakers must have had in mind . . . , but because it is [the judiciary's] role to make sense rather than nonsense out of the *corpus juris*." *Casey*, 499 U.S. at 100-01.

CONSTRUCTION § 46:06, at 194 (6th ed. 2000)). More specifically, this Court has repeatedly viewed the disparate inclusion and exclusion of particular language within the Medicare Act as strong evidence of congressional intent. *See, e.g., Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213-14 (1988) ("[W]here Congress intended to grant the Secretary the authority to act retroactively, it made that intent explicit. . . . § 1395x(v)(1)(A)(ii) directs the Secretary to establish procedures for making retroactive corrective adjustments; in view of this indication that Congress considered the need for retroactive agency action, the absence of any express authorization for retroactive cost-limit rules weighs heavily against the Secretary's position."); *United States v. Erika, Inc.*, 456 U.S. 201, 208 (1982) ("Conspicuously, [§ 1395ff] fails to authorize further review for determinations of the amount of Part B awards. In the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended to foreclose further review of such claims."). Accordingly, by giving the Secretary express discretion to extend the filing deadline for Medicare *beneficiary* appeals while omitting like authority from the provisions setting nearly identical deadlines for Medicare *provider* appeals, Congress signaled its intention to withhold such discretion in the latter context. *See Russello v. United States*, 464 U.S. 16, 23 (1983) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.") (internal quotation marks omitted). This Court should not construe two sets of provisions worded so differently to mean the same thing.

c. Respondents rely (at 22) on a series of cases involving what they deem to be "similar filing deadlines." But respondents can characterize these other deadlines as "similar" to § 1395*oo*(a) only by transforming this Court's context-sensitive inquiry into a one-dimensional *per se* rule. In fact, none of this Court's cases has found time limits to be nonjurisdictional when they have shared the two salient characteristics that mark § 1395*oo*(a)(3).

First, in *Henderson v. Shinseki*—upon which respondents place central reliance (at 23-24)—this Court emphasized that the timely filing requirement for appeals from the Board of Veterans' Appeals ("BVA") to the U.S. Court of Appeals for Veterans Claims ("Veterans Court") appears "in a subchapter [of the Veterans' Judicial Review Act, Pub. L. No. 100-687, Div. A, 102 Stat. 4105 (1988),] entitled 'Procedure,'" and not in the subchapter defining the tribunal's jurisdiction. 131 S. Ct. at 1205.[5] A similar consideration stood out in two other cases upon which respondents rely (at 22), *Kontrick v. Ryan*, *supra*, and *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385 (1982). *Kontrick* emphasized that the timely objection requirement there at issue appeared not in any statute defining the bankruptcy courts' jurisdiction, but rather in a Federal Rule of Bankruptcy Procedure issued pursuant to 28 U.S.C. § 2075. *See* 540 U.S. at 453-54. *Zipes* underscored that the timely filing requirement relevant there was contained in "an entirely separate provision" from those defining

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[5] The veterans' statute, moreover, explicitly defines the Veterans Court's jurisdiction in a distinct provision. *See* 38 U.S.C. § 7252(a) ("The Court of Appeals for Veterans Claims shall have exclusive jurisdiction to review decisions of the Board of Veterans' Appeals.").

the court's jurisdiction. 455 U.S. at 393-94.[6] In none of these cases, then, did this Court's holding entail the implausible notion that the statute in question *nowhere* defined the tribunal's jurisdiction—which is precisely what respondents' position would require this Court to conclude here, given that § 1395*oo*(a) constitutes the one and only provision that defines the classes of cases that the Board may hear.

Second, *Henderson* emphasized that the structural contrast between the filing deadline there at issue and another such deadline in the veterans' statute confirmed that the former was plainly nonjurisdictional. The related provision—which prescribes the method of taking an appeal from the Veterans Court to the U.S. Court of Appeals for the Federal Circuit—explicitly incorporates by reference the deadlines for noticing an appeal from a district court to a court of appeals. *See* 38 U.S.C. § 7292(a). Because this Court had long construed the deadlines incorporated by § 7292(a) to be jurisdictional, the Court found it significant that the provision specifically at issue—the one governing appeals from the BVA to the Veterans Court (38 U.S.C. § 7266(a))—is "not framed in comparable terms." *Henderson*, 131 S. Ct. at 1205. The Medicare Act's disparate treatment of beneficiary and provider filing deadlines, in contrast, points to the opposite conclusion in this case—namely, that § 1395*oo*(a)(3)'s timely filing requirement is strictly jurisdictional.

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[6] This Court added that the legislative history to Title VII of the Civil Rights Act of 1964 suggested that key legislators understood the timely filing requirement as a statute of limitations. *See Zipes*, 455 U.S. at 394.

Buttressing its structural comparison, the *Henderson* Court found the "most telling" evidence of legislative intent to be the fact that the veterans' review scheme as a whole reflected procedural informality, flexibility, and solicitude for veterans. *Id.* at 1205-06; *see also id.* at 1206 (concluding that reading the filing deadline for the Veterans Court as jurisdictional would "clash sharply with [the overall] scheme"). Similarly, in two other cases on which respondents rely, the Court found that the overarching remedial frameworks at issue called for special solicitude for plaintiffs' procedural rights. *See Burnett v. New York Central R.R. Co.*, 380 U.S. 424, 427 (1965) (arguing that equitable tolling served the "humane and remedial" purposes of the Federal Employers' Liability Act); *Honda v. Clark*, 386 U.S. 484, 495-98 (1967) (stressing that Congress consciously modeled the Trading with the Enemy Act's remedial scheme after bankruptcy statutes that had long incorporated equitable tolling). In contrast, the Medicare Act draws sharp lines between its flexible treatment of beneficiary deadlines and its stringent requirements for generally more sophisticated Medicare providers. *Cf. Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 456 (1999) (discussing the sophistication of Medicare providers in general).

In light of these considerations, the prescription of a filing deadline is the *only* thing that § 1395*oo*(a) has in common with the statutes in the cases on which respondents rely. In fact, if one looks beyond respondents' one-dimensional approach to jurisdiction, the contextual factors that define § 1395*oo*(a) strongly point to jurisdictional status.

2. In addition to the foregoing arguments, respondents and petitioner offer various contentions

resting on generalized assertions of legislative intent and purpose and (in petitioner's case) on well-known, but ultimately inapposite, principles of administrative law. None of those arguments, however, can overcome the clear import of § 1395*oo*(a)'s text and the clarifying backdrop of the Medicare Act's overall structure.

a. Respondents—here joined by petitioner—urge this Court to hold that Congress has acquiesced in a flexible understanding of § 1395*oo*(a)(3) by repeatedly amending the statute without disavowing the longstanding regulatory "good cause" exception to subsection (a)(3). Pet. Br. 20, 43; Resp. Br. 34; *see* 42 C.F.R. § 405.1841(b) (2007). There is no evidence, however, that Congress intended to endorse, much less adopt, the flexible understanding of subsection (a)(3) implicit in the Secretary's regulation.

At one time, this Court took the view that, when Congress revises an organic act without altering a longstanding agency interpretation of that act, Congress's failure to express disapproval could constitute persuasive evidence that the agency's position captured legislative intent. *See, e.g.*, *CFTC v. Schor*, 478 U.S. 833, 846 (1986); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 274-75 (1974). Recognizing the "limitations" of acquiescence "as an expression of congressional intent," this Court has in recent years deemed it "'impossible to assert with any degree of assurance that congressional failure to [overturn an established interpretation] represents' affirmative congressional approval of [that] interpretation." *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 186 (1994) (quoting *Patterson v. McLean Credit Union*, 491 U.S. 164, 175 n.1 (1989)). Congress may fail to correct an existing interpreta-

tion of a statute for any number of reasons, including the dilatory effect of parliamentary tactics, a failure to focus on the problem, the absence of any firm legislative view about the correctness of an interpretation, or the desire not to confront important interest groups. *See, e.g.*, *Rapanos v. United States*, 547 U.S. 715, 750 (2006) (plurality opinion) (discussing potential reasons for legislative inaction); *Helvering v. Hallock*, 309 U.S. 106, 119-21 (1940) (same). As Justice Frankfurter once wrote for the Court, "we walk on quicksand when we try to find in the absence of corrective legislation a controlling legal principle." *Hallock*, 309 U.S. at 121.

Accordingly, while this Court has found "congressional acquiescence to administrative interpretations of a statute in some situations, [it has] done so with extreme care." *Solid Waste Agency of Northern Cook County v. United States Army Corps of Eng'rs*, 531 U.S. 159, 169 (2001) ("*SWANCC*"). In particular, this Court has explained that, "[a]bsent ... overwhelming evidence of acquiescence, [it is] loath to replace the plain text and original understanding of a statute with an amended agency interpretation." *Id.* at 169 n.5. Thus, in *SWANCC*, this Court made clear that inferring acquiescence is appropriate where the legislative record indicates that Congress was aware of the agency's position and, in some way, strongly signaled its approval or acceptance of that position. *See id.*; *see also Bob Jones Univ. v. United States*, 461 U.S. 574, 600-01 (1983) (finding acquiescence in light of multiple committee hearings on the precise agency interpretation at issue and Congress's rejection of 13 separate proposed bills aimed at overturning that interpretation). In this case, petitioner and respondents offer *no* evidence that Congress was aware

of the "good cause" regulation when it amended § 1395*oo*,[7] much less that Congress showed any disposition to embrace that interpretation.[8]

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[7] Further, even if one assumed that Congress *were* generally aware of the agency's construction of § 1395*oo*(a)(3), one would still have a hard time pinning down the precise position in which Congress putatively acquiesced. As discussed in our opening brief, the Secretary, CMS, and the Board have long held internally inconsistent views on § 1395*oo*(a)(3)'s jurisdictional status. *See Amicus* Br. 42-47 (explaining that, notwithstanding the Secretary's "good cause" exception, all of the agencies charged with implementing subsection (a)(3) have repeatedly characterized that provision as a jurisdictional prerequisite to the exercise of the Board's jurisdiction).

[8] Petitioner correctly notes (at 48) that at least one congressional committee was aware that, several months prior to the enactment of § 1395*oo*, the Department of Health, Education, and Welfare ("HEW") had promulgated a set of regulations establishing a scheme in which providers dissatisfied with their reimbursements could seek hearings from intermediaries. *See* S. Rep. No. 92-1230, at 248 (1972) (referring to HEW's regulations). As petitioner notes (at 48), moreover, one of HEW's pre-enactment regulations prescribed a regulatory "good cause" exception "virtually identical" to the one at issue in this case. *See* 20 C.F.R. § 405.493 (1973). To the extent that the pre-enactment HEW regulations served as a model for § 1395*oo*, however, they cut against finding that Congress embraced the "good cause" exception prescribed by the regulations. The regulation establishing a right to an intermediary hearing prescribed the same sort of jurisdictional elements as § 1395*oo* ultimately set forth—a "dissatisfaction" requirement governing the subject matter of the hearings, a $10,000 amount-in-controversy requirement, and a 60-day timely filing requirement. *See id.* § 405.492(a). The "good cause" exception appeared in the very next regulatory provision. If Congress used the HEW regulations as a model for § 1395*oo*, it is significant that Congress patterned § 1395*oo*(a) after § 405.492(a) but did not incorporate any form of the "good cause" exception found in the immediately adjacent § 405.493. Accordingly, if Congress's awareness of the pre-enactment HEW regulations tells us

b. Respondents argue (at 33-34) that reading § 1395*oo*(a) as jurisdictional will thwart the statute's general purpose of "establish[ing] the Board to give providers the right to an administrative hearing to assure accuracy in their payments," and that treating the filing period as "nonjurisdictional is the only viable mechanism for enforcing a much-needed institutional check on agency missteps, knowing miscalculations, and other serious errors."[9] Reasoning from such general purposes to specific statutory outcomes is particularly treacherous when it comes to the design of timely filing requirements. Such requirements, by their nature, sometimes cut off meritorious claims in order to serve "a broader system-related goal, such as facilitating the administration of claims, limiting the scope of a governmental waiver of sovereign immunity, or promoting judicial efficiency." *John R. Sand & Gravel*, 552 U.S. at 133-34 (citations omitted). In other words, the systemic objective of protecting administrative workability through the imposition of filing deadlines necessarily comes at "the price of occasional unfairness in indi-

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anything, it is that Congress opted *against* adopting the "good cause" exception that accompanied its model for the Board's jurisdiction.

[9] Respondents (at 33) and *amicus* Southwest Consulting Associates, LP (at 5) argue that equitable tolling is particularly necessary here because of alleged agency concealment of facts necessary for respondents to challenge their adjustment for serving a "disproportionate share" of low income patients under the Act. These factual allegations, however, go to the ultimate question whether equitable tolling would be appropriate, if available, and not to the antecedent legal question whether Congress adopted a categorical jurisdictional deadline that precludes equitable tolling.

vidual cases." *United States v. Brockamp*, 519 U.S. 347, 352-53 (1997).

Accordingly, it is uninformative to emphasize, as respondents do, that reading a timely filing requirement as jurisdictional will sometimes preclude a provider from receiving payments they are due. To say that the purpose of the Medicare Act is to ensure the payment of meritorious claims is to say nothing about how Congress struck the balance between that goal, on the one hand, and the competing goals of administrability and repose, on the other. Respondents offer no evidence to suggest that reading § 1395*oo*(a) as jurisdictional would contradict a specific purpose articulated in the text of the statute or even its legislative history.[10] To the contrary, the Medicare Act's disparate treatment of the respective deadlines for beneficiary and provider appeals demonstrates that Congress knew how to provide for administrative flexibility in Medicare appeals and opted against doing so where provider appeals are concerned. To disregard that concrete and direct textual signal in favor of respondents' generalized assertions of purpose would disregard the fact that interpreters are "bound, not only by the ultimate

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[10] The legislative history says almost nothing about the particular character of the timely filing requirement. To the extent that it does, the House and Senate committee reports merely state that any provider of services "which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary" and that "[t]he appeal must be filed within 180 days after notice of the fiscal intermediary's final determination." H.R. Rep. No. 92-231, at 108 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5094; S. Rep. No. 92-1230, at 249. Nothing in that description suggests that the House or Senate committee, at least, affirmatively contemplated the sort of flexibility that respondents would attribute to the statute.

purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994).

c. Petitioner argues that general principles of administrative law justify her regulatory "good cause" exception to § 1395*oo*(a)'s 180-day timely filing requirement. In particular, petitioner contends that "'agencies should be free to fashion their own rules of procedure'" as long as the resultant rules are not arbitrary, capricious, or contrary to law. Pet. Br. 17 (quoting *Vermont Yankee Nuclear Power Corp. v. Natural Res. Def. Council, Inc.*, 435 U.S. 519, 543-44 (1978)). From that starting point, petitioner argues that, while it is "reasonable . . . to characterize th[e] time limit as 'jurisdictional' in the sense that it constrains the Board's adjudicative powers," the Secretary's "authority to interpret and implement Section 1395*oo*" enables her "to extend the time limit in certain circumstances." *Id.* at 47. Accordingly, she argues, the statutory filing deadline and the implementing regulations—including the regulatory "good cause" exception to subsection (a)(3)—"*together* establish the time limits on the Board's adjudicative powers." *Id.*

Petitioner's argument begs the question. This Court has made clear that, because jurisdictional rules define a tribunal's very authority to act, such rules are absolute and not subject to waiver, forfeiture, or (in the case of filing deadlines) equitable tolling. *See, e.g., Gonzalez v. Thaler*, 132 S. Ct. 641, 648 (2012); *Dolan v. United States*, 130 S. Ct. 2533, 2538 (2010); *John R. Sand & Gravel*, 552 U.S. at 133-34; *United States v. Cotton*, 535 U.S. 625, 630 (2002). Accordingly, because § 1395*oo* is jurisdictional, the

Secretary may not authorize the Board, in effect, to waive the statutory filing deadline where conditions specified by the Secretary are met. This reality precludes the Secretary from simultaneously asserting (at 47) that "Section 1395*oo*(a)(3) limits the Board's jurisdiction" but "does not preclude the Secretary from adopting a . . . good-cause [exception]" to that jurisdictional limit.

3. Finally, the unsustainable breadth of respondents' position is underscored by their contention (at 26-28) that *no* part of subsection (a)—including its dissatisfaction and amount-in-controversy requirements—is jurisdictional. Initially, respondents argue (at 27) that, "for decades without congressional objection, the Board has been empowered to issue decisions on matters other than those specifically listed" among subsection (a)(1)'s subject-matter requirements. As noted in our opening brief (at 21 n.12), however, the Board, CMS, and the Secretary herself have all consistently treated subsection (a)(1)'s "dissatisfaction" requirement as binding, nonwaivable, and jurisdictional. Respondents do not cite a single instance in which the Board has claimed authority to adjudicate a matter falling outside subsection (a)(1)'s ambit. Nor do respondents point to a single sentence in any applicable regulation, regulatory docket, or decision of the Board or CMS that suggests that any agency responsible for implementing this review scheme regards the subject-matter requirements of subsection (a)(1) as optional.[11]

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[11] Rather, in support of their view that the Board may hear cases that fall outside subsection (a)(1)'s scope, respondents point only to a 1987 rulemaking that, in their view, permits the Board to review "hospitals' challenges to the specific diagnosis-related group [("DRG")] assigned to their inpatient stays, even

Respondents further argue (at 27) that the "amount-in-controversy requirement is not jurisdictionally absolute." In fact, the Board has treated that provision as a jurisdictional requirement akin to that contained in 28 U.S.C. § 1332. *See, e.g.*, *Winn Parish Med. Ctr. v. Wisconsin Physicians Serv.*, No. 2011-D33, 2011 WL 2574353, at *7 (PRRB June 15, 2011); *see also Amicus* Br. 22 n.13. Respondents nevertheless contend (at 27-28) that, by permitting providers "to aggregate claims for two or more fiscal years in order to meet the minimum amount in controversy requirement for group appeals," the Secretary has displayed a "flexib[ility]" in construing § 1395*oo*(a)(2) that is inconsistent with jurisdictional status. This argument is flawed in two respects. First, the regulations permit such aggregation only in group appeals under subsection (b), and not in individual appeals under subsection (a)(2). *See* 42 C.F.R. § 405.1839(a)(2) (2011).[12] Second, a regulation

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though such review would not be 'with respect to [a] cost report,' or a 'final determination.'" as required by subsection (a)(1). Resp. Br. 27 (citing 52 Fed. Reg. 33,034, 33,047 (Sept. 1, 1987)) (second alteration in original). In fact, the rulemaking in question has little to do with *Board* review of DRG classifications. *See* 52 Fed. Reg. at 33,047. Instead, the docket to which respondents advert merely prescribes a mechanism for an intermediary or a Peer Review Organization to make corrections in a DRG within 60 days of the notice of initial classification. *See id.* at 33,045-33,047. While the concise and general statement of basis and purpose accompanying the regulation states, in passing, that a provider may obtain Board review of erroneous DRG assignments, *id.* at 33,047, that document says nothing to suggest that the Board may hear such challenges in cases that do not otherwise satisfy the jurisdictional requirements of § 1395*oo*(a). Nor do respondents point to any case in which the Board or CMS has asserted such authority.

[12] In contrast with subsection (a)(2), subsection (b) specifies the requirement that "the amount in controversy is, *in the*

that permits a plaintiff to aggregate multiple claims against a single defendant to meet an amount-in-controversy requirement is fully consistent with a jurisdictional understanding of that requirement. *See, e.g., Snyder v. Harris*, 394 U.S. 332, 335 (1969) (explaining that "[a]ggregation has been permitted [to meet the amount-in-controversy requirement in diversity cases] . . . in cases in which a single plaintiff seeks to aggregate two or more of his own claims against a single defendant"). Respondents, again, have cited no applicable regulation, regulatory docket, or adjudicative decision by any relevant agency suggesting that the responsible agencies regard subsection (a)(2) as nonjurisdictional.

Finally, respondents' position on subsections (a)(1) and (a)(2) reveals a fundamental flaw in their overall claim that subsection (a) is nonjurisdictional.[13] If one

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aggregate, $50,000 or more." 42 U.S.C. § 1395oo(b) (emphasis added). Whether that qualifier is properly construed to apply to the aggregation of claims over multiple years or, more likely, to the aggregation of claims of multiple providers in the group appeal, the difference in language provides at least an arguable basis for the agency's approach. *Cf. St. Francis Med. Ctr. v. Sullivan*, 962 F.2d 1110, 1114-16 (3d Cir. 1992) (distinguishing subsection (a)(2) from subsection (b) for purposes of claim aggregation).

[13] Respondents are surely correct that "there is no rule of jurisdiction by association." Resp. Br. 28. That is, subsection (a)(3) is not jurisdictional merely by virtue of its proximity to subsections (a)(1) and (a)(2). Instead, the important point is that all three provisions together comprise a unified whole. These provisions are identical in their textual structure, their placement in the Act, and their evident purpose. Subsection (a)(3) is jurisdictional not because it is proximate to other jurisdictional requirements, but rather because it is part and parcel of an integrated provision all of whose components together define the Board's authority to act.

looks at the three subparts of subsection (a) together, it becomes apparent that Congress carefully considered the detailed criteria it wished to set as preconditions for the invocation of the Board's authority. Contrary to respondents' contentions (at 26), subsection (a)(1)'s subject-matter criteria are neither "flexible" nor "indeterminate,"[14] but rather lay out in studied detail what kinds of claims the agency may hear.[15] The amount-in-controversy and timely filing

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[14] Respondents further assert (at 26) that, "to [their] knowledge, Congress has not before employed" a "dissatisfaction" requirement "to draw jurisdictional lines." Instead, they maintain (*id.*) that Congress "not uncommonly employs similar 'dissatisfaction' phraseology" as a simple trigger for administrative review. In support, respondents merely cite (*id.*), without elaboration, three statutes that employ that term. They offer *no* authority suggesting that "dissatisfied" is a term of art signaling the adoption of a nonjurisdictional requirement. (Indeed, whatever affirmative weight one might attach to this Court's observation that § 1395*oo*(a)(1) imposes "a condition to the Board's jurisdiction," *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 404 (1988), that statement is hard to square with any contrary assertion that "dissatisfication" constitutes an established term of art connoting a nonjurisdictional requirement.) Respondents' one-dimensional focus on a single word again ignores this Court's direction to determine jurisdictional status in light of the statute's text, context, structure, and purpose. *See Amicus* Br. 16.

[15] First, review is available if the provider is "dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by [a cost] report." 42 U.S.C. § 1395*oo*(a)(1)(A)(i). Second, a provider may invoke the Board's authority if "dissatisfied with a final determination of the Secretary as to the amount of the payment under" the prospective payment system prescribed by § 1395ww(b) and (d). *Id.* § 1395*oo*(a)(1)(A)(ii). Finally, the provider may seek redress before the Board if the provider "has

requirements are, moreover, crisp and unqualified. To the extent that respondents are suggesting that Congress has given the Board flexibility to assert authority over cases that do not satisfy the carefully specified requirements of § 1395*oo*(a), their position reflects an implausible reconstruction of Congress's likely intent. *Cf. MCI*, 512 U.S. at 231 (narrowly reading express statutory authority to "modify" a requirement of the Communications Act of 1934 in order to avoid nondelegation concerns).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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not received [a] final determination from [an] intermediary on a timely basis after filing [a cost] report, where such report complied with the rules and regulations of the Secretary relating to such report." *Id.* § 1395*oo*(a)(1)(B); *see also id.* § 1395*oo*(a)(1)(C) (authorizing review of untimely responses to a "supplementary cost report").

AMICUS CURIAE BRIEF

No. 11-1231

IN THE

Supreme Court of the United States

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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

STATEMENT OF INTEREST[1]

The American Hospital Association respectfully submits this brief as *amicus curiae*.

The American Hospital Association represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. AHA members are committed to

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amicus curiae*, its members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties have given their consent to this filing in letters that have been lodged with the Clerk.

improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

Integral to AHA's mission of achieving quality and affordable health care is ensuring that hospitals are promptly and correctly paid for services rendered. A significant portion of those payments come from Medicare and Medicaid, programs overseen by the Secretary of Health and Human Services and the Center for Medicare and Medicaid Services (CMS). In 2011, Medicare covered 48.7 million people and paid $541.3 billion in benefits, $167.8 billion of which went to hospitals. Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report* 10 tbl. II.B.1 (Apr. 23, 2012).[2]

AHA supports CMS's attempts to provide hospitals with a transparent, fair, and streamlined administrative process to correct inaccurate payments. But that administrative process cannot work if it is not properly overseen from the outside. Any administrative system that reviews provider reimbursement—including the Provider Reimbursement Review Board (PRRB)—should also allow for robust judicial review of the system's administrative findings. Limiting judicial review of the reimbursement review process through rigid time limitations—as the Secretary and Court-appointed *amicus* propose—

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[2] *Available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf.

would be contrary to Congress's intent, skew incentives for CMS employees, reduce transparency, and harm hospitals.

SUMMARY OF ARGUMENT

1. As Respondents cogently explain, the 180-day time limit on appeals to the PRRB should be subject to ordinary principles of equitable tolling. " '[J]urisdiction * * * is a word of many, too many, meanings.' " *Arbaugh* v. *Y&H Corp.*, 546 U.S. 500, 510 (2006) (quoting *Steel Co.* v. *Citizens for Better Env't*, 523 U.S. 83, 90 (1998)). Thus, the Court has held that unless Congress itself " 'rank[s] a statutory limitation on coverage as jurisdictional, courts should treat the restriction as nonjurisdictional.' " *Gonzales* v. *Thaler*, 132 S. Ct. 641, 648 (2012) (quoting *Arbaugh*, 546 U.S. at 516). Neither the Secretary nor the Court-appointed *amicus* can point to anything that is a sufficiently "clear[ ] statement," *id.* at 649, to overcome the strong presumption that Congress intended the 180-day time limit on PRRB review to be nonjurisdictional. Thus, ordinary tolling principles, such as equitable tolling, should apply. *See Irwin* v. *Dep't of Veteran Affairs*, 498 U.S. 89, 95-96 (1990).

2. But this case's importance goes well beyond the seemingly technical question of whether the 180-day time limit is "jurisdictional," Court-Appointed Amicus Br. 14-48; "not jurisdictional in the strictest sense of that term," SG Br. 47; or a "claims-processing rule," Respondents' Br. 21. Whether the courts have the power to toll the 180-day time limit will have a profound impact on both outside oversight of the Medicare program and hospitals' ability to serve Medicare beneficiaries.

a. The Medicare Act has been called "among the most completely impenetrable texts within human experience." *Rehab Ass'n of Va.* v. *Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994); *see also Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011) ("lamenting the complexity of" the "regulatory behemoth" that is the Medicare Act). But among all of its complexities, one thing in the Act is perfectly clear: Congress intended for there to be, at the end of Medicare's administrative labyrinth, an opportunity for judicial review. Judicial review ensures that there is a meaningful check on CMS's otherwise complete control of the Medicare system. The Secretary and Court-appointed *amicus*'s constructions of the 180-day appeal period, however, erroneously place finality above all else—even above the federal courts' traditional role in correcting agency errors.

b. Adopting the Secretary or Court-appointed *amicus*'s rule will impose an enormous financial and administrative burden on hospitals. Hospitals already commit tremendous sums to caring for the elderly and vulnerable, covering billions in costs that Medicare does not fully reimburse and providing billions more in charity care. The Secretary and Court-appointed *amicus*'s rules would add to those burdens by forcing hospitals to bear the additional cost imposed by CMS's undetectable mistakes. And it is the safety-net hospitals—which depend the most on government aid to make ends meet and serve the most underserved populations—that will be harmed the most if the Secretary or Court-appointed *amicus*'s rule becomes law.

c. The Secretary's only justification for forcing hospitals to shoulder the additional burden of CMS's

mistakes is that it saves the agency the administrative trouble of reopening older claims. But CMS already reopens supposedly stale claims as part of its efforts to recoup alleged past *overpayments*, imposing significant burdens on hospitals in doing so. This Court should reject an interpretation of the Medicare statute that benefits only CMS and its agents.

ARGUMENT

I. CATEGORICALLY BARRING EQUITABLE TOLLING OF THE 180-DAY PRRB TIME LIMIT WOULD FLOUT CONGRESSIONAL INTENT AND FURTHER OBSCURE THE ALREADY OPAQUE WORKINGS OF CMS.

At the heart of the Medicare Act's administrative- and judicial-review provisions is a balance. On one hand, Congress granted the Secretary authority to decide questions arising from the Medicare Act in the first instance. *See Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 12-13 (2000). On the other, Congress understood that administrative process could only be fair if there was an adequate opportunity for judicial review at the process's end. *See Bowen* v. *Mich. Academy of Family Physicians*, 476 U.S. 667, 670-681 (1986).

The Secretary and Court-appointed *amicus*'s interpretations of the PRRB's jurisdiction upset that balance. Both of their rules lead to the same conclusion: So long as a CMS mistake in payment calculation goes undetected for over 180 days—even if providers could not have discovered the error in that time—the federal courts must stand idly by. That is wrong as a matter of law. And it would create skewed incentives: If no one—or only CMS—can craft a remedy when a CMS mistake remains undis-

covered for over 180 days, it will encourage the agency to discover errors only on the 181st day. Those incentives will further reduce the transparency of CMS's data-collection and payment-calculation processes. And that in turn will only add to the PRRB backlog that the Secretary and Court-appointed *amicus*'s rules purport to reduce. The bottom line of all three of these impacts is a less accountable, less efficient Medicare system—the opposite of what Congress intended.

1. A bedrock principle of administrative law is the "strong presumption in favor of judicial review of administrative action." *INS* v. *St. Cyr*, 533 U.S. 289, 298 (2001); *accord Gutierrez de Martinez* v. *Lamagno*, 515 U.S. 417, 425 (1995). As Chief Justice Marshall himself put it over 170 years ago, it would "excite some surprise if" an administrative officer could "levy * * * any sum he might believe due, leaving to that debtor no remedy, no appeal to the laws of his country, if he should believe the claim to be unjust." *United States* v. *Nourse*, 34 U.S. (9 Pet.) 8, 28-29 (1835). But "this anomaly does not exist." *Id.* Congress has concurred. Denying judicial review for violations of the law, it wrote in its Report on the Administrative Procedure Act, "would in effect" allow "blank checks drawn to the credit of some administrative officer or board." S. Rep. No. 752, at 26 (1945).

To be sure, Congress may *defer* judicial review, channeling it through the administrative agency in the first instance. In such a case, the judicial-review presumption is not immediately implicated. *Thunder Basin Coal Co.* v. *Reich*, 510 U.S. 200, 207 & n.8 (1994). But judicial review in those circumstances is not "ousted, but only postponed." *United States* v.

Philadelphia Nat'l Bank, 374 U.S. 321, 353 (1963). The supervisory role this Court presumes for the judiciary will still be carried out; it just takes place on a different timetable. *See Illinois Council*, 529 U.S. at 23-24.

Congress has chosen this deferred approach to judicial review for the Medicare system. The Medicare Act channels review through the PRRB by replacing the federal courts' general federal-question jurisdiction with a specific jurisdictional grant allowing providers to challenge an adverse PRRB ruling in the district court within 60 days. 42 U.S.C. § 1395oo(f)(1) (PRRB judicial-review provision); *Illinois Council*, 529 U.S. at 16-18. This funneling mechanism gives CMS "the opportunity to reconsider its policies, interpretations, and regulations" in light of the challenges brought by providers. *Illinois Council*, 529 U.S. at 16-18. It also permits the agency to save parties time and money by resolving payment disputes at an early stage and in a less formal setting.

But despite implementing an agency-first dispute-resolution process, Congress still meant for judicial review to serve as an important check on the administrative process. *See Rehab Ass'n of Va.*, 42 F.3d at 1450 (deference to CMS "did not replace Article III of the Constitution"). Indeed, throughout the Medicare Act's history Congress has *expanded* opportunities for providers to obtain administrative and judicial review, and thereby constricted CMS's ability to promulgate contrary regulations. *See, e.g.*, Social Security Amendments Act of 1972, Pub. L. No. 92-603, § 243(a) (codified at 42 U.S.C. § 1395oo) (establishing administrative and judicial review process governing provider payments that displaced previous

CMS-developed regulations); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L. 108-173, § 932 (codified at 42 U.S.C. § 1395ff(b)(F)) (requiring Secretary to establish process of expedited access to judicial review for challenges to agency regulations, displacing existing regulations on topic).

This Court, too, has recognized that courts must step in to protect judicial review when the Secretary's regulations deny effective relief. In *Michigan Academy*, the Court rejected the Secretary's contention that Congress intentionally left CMS's implementation of Medicare Part B unreviewable by the courts, instead locating a right of action under the general federal-question-jurisdiction statute. 476 U.S. at 680-681. In *Illinois Council*, the Court confirmed that the otherwise absolute channeling requirement of the Medicare Act does not apply where channeling would cause a "complete preclusion of judicial review." 529 U.S. at 22-23 (emphasis omitted). And in implementing these decisions, the lower courts have recognized that CMS's comprehensive process can be bypassed when traversing it would be practically impossible for providers. *See Council for Urological Interests* v. *Sebelius*, 668 F.3d 704, 713-714 (D.C. Cir. 2012); *Nat'l Ass'n of Psychiatric Health Sys.* v. *Shalala*, 120 F. Supp. 2d 33, 38-39 (D.D.C. 2000). All of these decisions acknowledge the paramount importance of ensuring judicial review, even in the face of the Medicare Act's channeling provisions. And they recognize as much even when CMS would otherwise prefer to limit judicial review in the name of administrative efficiency.

In sum, "Congress intends the executive to obey its statutory commands and, accordingly, * * * it expects

the courts to grant relief when an executive agency violates such a command." *Michigan Academy*, 476 U.S. at 681. Thus, Congress intends for the courts, at the end of CMS's administrative process, to have "adequate authority to resolve any * * * contention the agency does not, or cannot, decide." *Illinois Council*, 529 U.S. at 1.

2. The Secretary and Court-appointed *amicus*'s constructions of the 180-day PRRB review deadline would strip the federal courts of that authority. That is because both of their rules amount to this: If a CMS error is concealed for 181 days, even if the affected providers could not discover it on their own, the federal courts are powerless—under any circumstances, regardless of any equities—to step in. This Court should reject such a harsh result. *See Nat'l R.R. Passenger Corp.* v. *Morgan*, 536 U.S. 101, 121 (2002) (equitable tolling is available whenever " 'equity so requires.' ") (citation omitted). Congress's intention that the executive obey its statutory commands is toothless if the executive can insulate its disobedience from review as long as it goes unnoticed for a mere six months—a flash in the pan in hospital reimbursement years.

The Secretary offers assurances that CMS's mistakes will not go unremedied; hospitals, she says, are "sophisticated Medicare-provider recipients" who should be able to spot agency errors quickly. SG Br. 28. But the equitable-tolling doctrine already takes that into account. It requires the claimant to prove both " '(1) that he has been pursuing his rights diligently, and (2) that some extraordinary circumstance stood in his way' and prevented timely filing." *Holland* v. *Florida*, 130 S. Ct. 2549, 2653 (2010)

(quoting *Pace* v. *DiGuglielmo*, 544 U.S. 408, 418 (2005)). In a routine case where the mistake is one the provider could and should have caught, the equitable-tolling question should be an easy one.

The Secretary's back-up response is that a deadline that does not allow for equitable tolling serves "[p]rinciples of finality and repose." SG Br. 30. There is no doubt that "finality and repose" are goals of the Medicare Act. They are goals of any time limitation. *See Am. Pipe & Construction Co.* v. *Utah*, 414 U.S. 538, 554 (1974). Yet the goal of finality "is frequently outweighed * * * where the interests of justice require vindication of the plaintiff's rights." *See Burnett* v. *N.Y. Cent. R. Co.*, 380 U.S. 424, 428 (1965). That is as true in the Medicare Act as anywhere else. *Cf. Bowen* v. *City of New York*, 476 U.S. 467, 480 (1986) (applying equitable tolling to Social Security Act and its similarly intricate channeling provision). As this Court has warned time and again, " 'no legislation pursues its purposes at all costs' "; " 'it frustrates rather than effectuates legislative intent * * * to assume that *whatever* furthers the statute's * * * objective must be the law.' " *Pension Benefit Guar. Corp.* v. *LTV Corp.*, 496 U.S. 633, 646-647 (1990) (quoting *Rodriguez* v. *United States*, 480 U.S. 522, 525-526 (1987)). The Secretary's focus on "finality and repose" violates this cardinal principle.

Equally important as "finality and repose," then, is a judicial check on CMS's payment errors when extraordinary circumstances prevent providers from protesting those errors within six months. And while providers bear the burden of establishing those "extraordinary circumstances," *Pace*, 544 U.S. at 418,

the equities are on providers' side in other respects, for "the Secretary has the capability and duty to prevent the illegal policy" the claimants are challenging. *See City of New York*, 476 U.S. at 487. The 180-day time limitation should not be a bright line that bars courts from correcting " 'particular injustices' " through the doctrine of equitable tolling. *Holland*, 130 S. Ct. at 2563 (quoting *Hazel-Atlas Glass Co.* v. *Hartford-Empire Co.*, 322 U.S. 238, 248 (1944)).

3. That is particularly so because of the incentives that the Secretary and Court-appointed *amicus*'s rules create. There are "hundreds of calculations that go into an annual determination of the amount due to a provider for any given cost reporting period." SG Br. 30. And any one of those calculations—including some that apply to all providers participating in Medicare—can be the subject of a mistake by CMS employees or agents.

For instance, an error in calculating inpatient hospital rates between 1998 and 2007 led CMS to underpay hospitals by an estimated $3 billion. C. Terhune, *Medicare To Settle Hospital Reimbursement Dispute*, L.A. Times, Apr. 12, 2012.[3] A "technical error" in calculating readmissions penalties under the Affordable Care Act led CMS to belatedly tell 1,422 hospitals they owed more in penalties than initially projected. J. Rau, *Medicare Revises Hospitals' Readmissions Penalties*, Kaiser Health News, Oct. 2, 2012.[4] And even apart from these system-

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[3] *Available at* http://articles.latimes.com/2012/apr/12/business/la-fi-0413-medicare-settlement-20120412.

[4] *Available at* http://www.kaiserhealthnews.org/Stories/2012/October/03/medicare-revises-hospitals-readmissions-penalties.aspx.

wide miscalculations, smaller mistakes add up. CMS's own contractors identified $61.5 million in underpayments to providers in the second quarter of 2012 alone. CMS, *National Recovery Audit Program Quarterly Newsletter* (Mar. 2012).[5]

Errors big and small are inevitable in a system of Medicare's size. The question is what to do once they become apparent. AHA supports a "simple, transparent, and predictable" system where CMS shares the data underlying its payment calculations with providers. *See, e.g.*, Letter from American Hospital Ass'n to M. Tavenner, Acting Administrator, CMS, 14, 44 (June 19, 2012); *see also* 61 Fed. Reg. 46,166, 46,206 (Aug. 30, 1996) (noting that "[h]ospitals are increasingly frustrated by their inability to monitor" CMS's reimbursement calculations).[6] A transparent system would allow hospitals to double-check CMS's work and point out mistakes well within the 180 days permitted for PRRB review. A transparent system would also allow hospitals and CMS to work together to develop a payment-computation system that avoids both underpayments *and* overpayments.

The Secretary and Court-appointed *amicus*'s rules, however, would undercut these goals in three distinctive ways.

First, the Secretary and *amicus*'s rules would reduce transparency because they create an incentive

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[5] *Available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-2nd-qtr-2012.pdf.

[6] *Available at* http://www.aha.org/advocacy-issues/letter/2012/120619-cl-ipps.pdf.

to conceal mistakes rather than correct them. CMS is under tremendous pressure to contain Medicare costs. *See, e.g.*, CMS, *Affordable Care Act Update: Implementing Medicare Cost Savings* 1-2 (outlining the $418 billion in cost savings required by 2019 to extend the Trust Fund's solvency by 12 years)[7]; Editorial, *Fixing Medicare*, N.Y. Times, Nov. 20, 2011 (observing that politicians seek "big immediate cuts to slow Medicare spending").[8] Under the Secretary and *amicus*'s rules, the Government will retain any cost "savings" from underpayment errors that do not come to light within 180 days of the payment notices being issued. *Cf. Armstrong* v. *Executive Office of the President*, 1 F.3d 1274, 1284 (D.C. Cir. 1993) (" '[A]gencies, left to themselves, have a built-in incentive to dispose of records relating to [their] 'mistakes[.]' ") (citation omitted); *see also* Respondents' Br. 12-13 (detailing CMS's history of concealing the DSH errors at issue in this case).

To be sure, CMS employees generally are conscientious in the performance of their duties. "But agencies are run by people and people make mistakes. Review by a tribunal outside the agency helps correct these * * * errors." *Rodriguez-Roman* v. *INS*, 98 F.3d 416, 433 (9th Cir. 1996) (Kozinski, J., concurring). Equitable tolling gives CMS an incentive to share data so that providers may review their own reimbursement notices and identify costly mistakes *before* they are compounded through repetition. And it gives CMS employees and agents an incentive to

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[7] *Available at* http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf.

[8] *Available at* http://www.nytimes.com/2011/11/21/opinion/fixing-medicare.html.

promptly report errors before they become more harmful with time. *See* M.C. Stephenson, *The Price of Public Action*, 118 Yale L.J. 2, 32 (2008) ("[J]udicially imposed procedural requirements * * * increase accuracy by correcting mistakes ex post and by encouraging government decisionmakers to be more thoughtful and careful ex ante."). By contrast, if there were no review of CMS calculations after the 180-day window, it "leaves the problem of how [CMS] will learn from [its] mistakes, and, indeed, how [CMS] will even realize [it] ha[s] made a mistake." M.F. Cuellar, *Auditing Executive Discretion*, 82 Notre Dame L. Rev. 227, 262 & n.138 (2006); *see also* R.W. Parker, *Grading the Government*, 70 U. Chi. L. Rev. 1345, 1369 (2003) ("[A]gencies have little or no incentive to probe, in detail, the possibility of their own prior analytical mistakes.").

Second, allowing CMS to dole out exceptions to the 180-day PRRB review provision solely as a matter of its "grace," SG Br. 29, would create an incentive for CMS to develop administrative procedures that systematically favor it. Hospitals have already seen this incentive in action. After *Monmouth Medical Center* v. *Thompson*, 257 F.3d 807 (D.C. Cir. 2001), where the D.C. Circuit required CMS to reopen previously closed provider reimbursement determinations pursuant to CMS's existing regulations, the agency changed the regulations. The previous regulations required payment intermediaries to reopen a claim any time the Secretary notified them that a prior determination was inconsistent with applicable law. *Id.* at 809. The new rule sharply narrows that class of claims that must be reopened, providing that "[a] change of legal interpretation or policy by CMS * * * in response to judicial precedent * * * is not a

basis for reopening a CMS or intermediary determination." 42 C.F.R. § 405.1885(c)(2); *see also* 67 Fed. Reg. 49,982, 50,096 (Aug. 1, 2002). Similarly, the reopening regulations allow CMS to reopen a closed reimbursement claim past the existing three-year bar for "fraud or similar fault of any party" to the claim, 42 C.F.R. § 405.1885(b)(3), but deny hospitals access to that exception because (at least according to the Department of Justice) CMS is not a "party" to a reimbursement determination. SG Br. 7 n.5.

Doctrines such as equitable tolling counteract this one-way ratchet. They give hospitals a way to present otherwise untimely claims in exceptional circumstances not sufficiently accounted for by CMS's regulations. And the availability of those doctrines encourages CMS to craft more even-handed rules so that providers are not forced to appeal to general equitable principles to obtain relief from the agency's errors. *Cf.* SG Br. 22.

Finally, the Secretary and *amicus*' rules have the potential to increase—not diminish—the backlog at the PRRB. *See id.* at 24-25. That is because if a provider has even the slightest notion of an error in its payment notice, it will have to file an appeal before 180 days or lose its review rights. Such "protective appeals" have the potential to further clog an already jammed administrative system. *See* Letter from American Bar Ass'n, Health Law Section, to M. McClellan, Administrator, CMS 3-4 (Aug. 24. 2004) ("a large portion of the PRRB's backlog is comprised [of] * * * protective appeals").[9] The availability of

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[9] *Available at* http://www.americanbar.org/content/dam/aba/migrated/health/04_government_sub/media/PRRB.authcheckdam.pdf.

equitable tolling assures providers that if they genuinely have done their best to ensure the accuracy of their reimbursement notices, they do not need to file a provisional appeal. *Cf. id.* (arguing that *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449 (1999), committing reopening solely to CMS's discretion, led to "providers fil[ing] protective appeals regarding matters that otherwise, and prior to *Your Home*, would have been rectified through the reopening process."). They can rely on the "established" equitable doctrine of tolling, *Credit Suisse Sec. (USA) LLC* v. *Simmonds*, 132 S. Ct. 1414, 1421 (2012), and receive the reimbursement they should have, but did not, receive from CMS.

The bottom line: Permitting the 180-day PRRB appeal deadline to be equitably tolled in appropriate circumstances simultaneously serves the goals of ensuring judicial review and providing the agency incentives to maintain a transparent, fair, and streamlined administrative-review system. It is not a doctrine to be lightly appealed to or lightly applied. But it is an "ordinary background * * * principle[ ]," that "Congress was certainly aware of," *see id.*, and that this Court should apply to the Medicare statute.

II. THE SECRETARY'S RULE WILL HARM HOSPITALS.

The Government has portrayed Respondents' suit as an attempt to opportunistically raid the Medicare Trust Fund based on decades-old claims. Pet. 28. That accusation could not be further from the truth. Hospitals are underpaid by Medicare for their costs even when the program's reimbursements are proper and timely. And safety-net hospitals, which serve the nation's most vulnerable patient populations,

rely on proper Disproportionate Share Hospital (DSH) payments to meet their costs each year. Systematic underpayment errors like those alleged by Respondents exacerbate hospitals' problems. And preventing federal courts from applying traditional equitable doctrines to the PRRB appeal period will make hospitals' already perilous situation even worse.

Hospitals understand perhaps better than anyone that their fates are linked to a healthy and solvent Medicare Trust Fund. In seeking equitable tolling, hospitals simply are attempting to obtain the reimbursements they are owed for the services they provided. And they are doing so in a regulatory environment where CMS employs contractors charged with clawing back payments from hospitals and imposes heavy administrative burdens in the process. Hospitals do not seek preferential treatment through equitable tolling; they seek the fair treatment that lies at the core of the doctrine.

1. Despite the hundreds of billions of dollars the federal government spends on Medicare and Medicaid, hospitals are not getting rich off of those programs. In 2010, Medicare and Medicaid patients accounted for 57 percent of all care provided by hospitals, but hospitals lost a total of $27.9 billion providing that care. American Hosp. Ass'n, *Underpayment By Medicare And Medicaid Fact Sheet* 1-2 (2012).[10] $20.1 billion of that $27.9 billion loss was attributable to Medicare patients and means hospitals receive on average only 92 cents of reimburse-

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[10] *Available at* http://www.aha.org/content/12/2012medunderpayment.pdf.

ment for each dollar they spend treating Medicare recipients. *Id.* at 3.

That figure is only the latest in a decade-long history of losses. Losses on Medicare-recipient care have ranged from a low of $1.3 billion in 2000, when AHA began tracking them, to a high of $25.2 billion in 2009. *Id.* Hospitals lost money on Medicare patients in every single one of these years—a total loss of ***$152.9 billion*** between 2000 and 2010. *See id.* Those consistent deficits, in turn, mean that hospitals effectively underwrite part of the Medicare system by covering costs for government-insured patients that the government does not.

But bridging that Medicare-payment gap is only one of the benefits hospitals provide to their communities. Hospitals also provide significant amounts of uncompensated care to patients for which they are not reimbursed by anyone. That care added up to an additional $39.3 billion in 2010, or 5.8 percent of hospitals' total costs. *See* American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 4 (Jan. 2012).[11] Indeed, in the last decade, hospitals provided more than ***$300 billion*** in uncompensated care to the uninsured and under-insured. *Id.*

As these figures show, hospitals already do their part to contribute to the health and welfare of the communities they serve. But the Secretary and Court-appointed *amicus*'s constructions of the 180-day time limitation would ask hospitals to shoulder an even greater burden. Under their rules, hospitals would assume the cost of CMS's mistakes when those

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[11] *Available at* http://www.aha.org/content/12/11-uncompensated-care-fact-sheet.pdf.

mistakes are discovered 180 days after the notice of proposed reimbursement is received, even if the error could not have been caught sooner through diligent efforts. Hospitals should not be forced to bear the risk that some systemic administrative mistakes will be impossible to unearth before the PRRB appeal period has run.

2. Forcing hospitals to bear the consequences of CMS's latent errors would be particularly harmful in this case. The Medicare DSH funds at issue here go to hospitals that "serve a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(v). Combined with Medicaid DSH payments, these funds provide assistance to "safety-net hospitals" that serve a large number of low-income patients. *The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments* 1 (June 15, 2009) ("*The Basics*").[12] DSH payments help these hospitals—many of them publicly owned and operated[13]—maintain the resources to care for patients who often have nowhere else to turn for medical assistance. L. Fishman & J.D. Bentley, *The Evolution of Support for Safety-Net Hospitals* 34-35, Health Affairs (July 1997).

The importance of DSH payments to inner-city and rural safety-net hospitals cannot be overstated. In

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[12] *Available at* http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

[13] Kaiser Comm'n on Medicaid and the Uninsured, *Stresses to the Safety Net: The Public Hospital Perspective* 1-2, 9 (June 2005), *available at* http://www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf; *see also* Respondents' Br. 6 (twenty percent of Medicare DSH recipient hospitals are publicly owned and operated).

2009, the federal government allocated $10.1 billion for Medicare DSH payments. *See* Health Industry Distributors Ass'n, *Disproportionate Share Hospital (DSH) Payments, Health Care Reform* 1 (Sept. 2010).[14] These payments—together with Medicaid DSH—are the largest source of federal funding for uncompensated care and the largest source of public funding for many hospitals. *The Basics* at 1.

Medicare DSH payments are spread out over more than just safety-net hospitals, but they are an important source of funding for those hospitals in particular. For instance, Medicare DSH paid for five percent of all unreimbursed care at public safety-net hospitals in 2009. National Ass'n of Public Hosp., *2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times* 4 fig.5 (Feb. 2011).[15] And if Medicare DSH were significantly cut, the results would be catastrophic. One study found that a 75 percent cut in Medicare DSH—as mandated by the Affordable Care Act, 42 U.S.C. § 1395ww(r)—would drive the operating margins of the average privately owned California safety-net hospital from a barely positive 1.1 percent to *negative* 2.8 percent. Private Essential Access Community Hospitals, *The Impact of Medicare Disproportionate Share Reductions on Private Safety-*

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[14] *Available at* http://www.hida.org/App_Themes/Member/docs/GA/Reimbursement/Disproportionate%20Share%20Hospital%20(DSH)%20Payments.pdf.

[15] *Available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Characteristics-Survey-Research-Brief.aspx?FT=.pdf.

Net Hospitals in California 5 (Jan. 2011).[16] Another found that the 75 percent cut in Medicare DSH would by itself cause nearly 10 percent of urban safety-net hospitals to go from positive to negative operating margins. National Ass'n of Urban Hosp., *Financial Challenges To Urban Hospitals* (Jan. 2011).[17] Without Medicare DSH payments, many safety-net hospitals could not keep operating.

For these reasons, the argument that allowing equitable tolling in this case and others like it could result in "billions" in additional payments to hospitals, Pet. 28, cuts both ways. Even assuming enough cases would clear the high equitable-tolling bar to add up to billions of dollars in claims, those dollars rightfully belong to struggling hospitals. Every dollar of DSH money that CMS improperly retains is a dollar that should have gone to a hospital already fighting to provide care for the financially vulnerable. The notion that equitable tolling could produce more reimbursements for these hospitals is not a reason to rule out equitable tolling. It is a reason to allow it.

3. The Government dismisses the plight of safety-net and other hospitals. It suggests that this suit and others are driven not by financial necessity, but by "health care consulting firms" that have "every incentive to scour old cost reports looking for asserted reimbursement errors." Pet. 28. Those aspersions are puzzling. Of course hospitals enlist special-

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[16] *Available at* http://www.peachinc.org/wp-content/uploads/2011/03/January-2011-Impact-of-Medicare-DSH-cuts-to-Californias-private-safety-net-hospitals.pdf.

[17] *Available at* http://www.nauh.org/component/option,com_rubberdoc/format,raw/id,1/view,doc/.

ized outside help to navigate the warren of CMS's "exceedingly complex" regulations. SG Br. 15. CMS should in fact be intimately familiar with the need for such specialists, because it does precisely the same thing: It employs contractors whose job it is to "scour old [reimbursement claims] looking for asserted reimbursement errors." Pet. 28.

CMS retains private parties, known as Recovery Audit Contractors or RACs "for the purpose of identifying [Medicare] underpayments and overpayments and recouping overpayments." 42 U.S.C. § 1395ddd(h)(1). RACs review past Medicare claims for compliance with the payment rules. If the RAC determines that a claim resulted in an improper overpayment, it can recover the amount of the overpayment. American Hosp. Ass'n, *Medicare Recovery Audit Contractors (RACs): Permanent Program Basics* 1, 7-8 (Apr. 20, 2009).[18] The provider can challenge the RAC's finding, but the multi-level appeal process is expensive and cumbersome. American Hosp. Ass'n, *Program Integrity and Contractor Overlap* 2.[19]

Medicare RACs are paid for their efforts "on a contingent basis," 42 U.S.C. § 1395ddd(h)(1)(B)(i)—currently, between 9 percent and 12.5 percent of the overpayment amount. 76 Fed. Reg. 57,808, 57,809 (Sept. 16, 2011). Thus, the more claims a RAC reopens and rejects, the more the RAC is paid. And the evidence suggests that RACs improperly deny a

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[18] *Available at* http://www.ashrm.org/ashrm/advocacy/advisories/files/2009rac.pdf.

[19] *Available at* http://www.aha.org/content/12/12-ip-program-integ.pdf.

large number of claims; 74 percent of appealed RAC decisions are ultimately reversed. American Hosp. Ass'n, *Exploring the Impact of the RAC Program on Hospitals Nationwide* 50 (Feb. 15, 2012).[20]

The RAC program—and its attendant demand for archived medical records—has placed tremendous burdens on hospitals. An AHA survey of 1,800 hospitals revealed that 50 percent experienced increased administrative costs as a result of the RAC program. American Hosp. Ass'n, *Medicare & Medicaid Recovery Audit Contractors* 1.[21] Many have had to add new administrative personnel just to handle the demands of RAC audits. *Id.* And even though an overwhelming majority of providers prevail on appeal, many opt not to try. *Id.* The average appeal takes 18-24 months to wind its way through the process, and the cost of the appeal often will be greater than the amount of money clawed back by the RAC audit in the first place. *Id.* Yet hospitals still—as they must—comply with RAC demands.

CMS's attempts to look back at long-closed payments go beyond the RAC program. In a recent proposed rule, CMS sought to place an obligation on hospitals to look back *10 years* and identify possible overpayments so that those overpayments may be returned to the Medicare Trust Fund. 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012). Moreover, CMS has

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[20] *Available at* http://www.aha.org/content/11/11Q4ractracresults.pdf.

[21] *Available at* http://www.aha.org/content/11/racpolicypaper.pdf.

proposed to expand the reopening period from 3 to 10 years to support this new look-back obligation. *Id.*

The administrative burden this proposal places on hospitals is self-evident. It requires hospitals to keep books and records for longer than existing document-retention policies call for and may require them to maintain multiple software and information-technology systems to review and search those older records. *See* Letter from American Hosp. Ass'n to M. Tavenner, Acting Administrator, CMS 8 (Apr. 16, 2012)[22]. And because the proposed rule expands the period beyond which hospitals thought their reimbursements were final and unchallengeable, it will require hospitals to "defend payment claims on their merits * * * that had long since been closed." *Cf.* SG Br. 25. Yet CMS rejected these anticipated concerns by citing the "primary importance" of "protect[ing] the Medicate Trust Fund." 77 Fed. Reg. at 9186.

The point is this: CMS tolerates extensive reimbursement look-backs—including by third-party contractors—and the additional administrative burdens those programs entail when they benefit the agency, but decries those same contractors and burdens when the roles are reversed. *See* SG Br. 23-25. If this Court grants CMS unreviewable discretion over what exceptions to recognize to the 180-day appeal deadline—and if past is prologue—CMS will use that discretion to perpetuate and expand this uneven allocation of benefits and burdens.

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[22] *Available at* http://www.aha.org/advocacy-issues/letter/2012/120416-cl-CMS60037-p.pdf.

CONCLUSION

AHA fully supports responsible efforts to ensure that hospitals receive only what they are owed from Medicare—no more and no less. But the 180-day time limitation on PRRB appeals should not become a Medicare reimbursement cut. It should instead be interpreted as time limits ordinarily have been: subject in appropriate cases to the traditional, well-defined doctrine of equitable tolling.

For the foregoing reasons, the decision below should be affirmed.

Respectfully submitted,

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October 2012

AMICUS CURIAE BRIEF

11-1231

In The
Supreme Court of the United States

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

BRIEF OF BENJAMIN N. CARDOZO SCHOOL OF LAW TAX CLINIC AS *AMICUS CURIAE* IN SUPPORT OF THE RESPONDENTS

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INTEREST OF THE *AMICUS CURIAE* [1]

The Cardozo Tax Clinic represents, for free, low-income taxpayers with respect to their federal income tax matters – both before the Internal Revenue Service and in the federal courts. Occasionally, the Clinic's assistance has been sought after those individuals, on their own, filed a document late – either with the IRS or the courts -- under a time deadline set out in the Internal Revenue Code or in a regulation promulgated thereunder. Usually, no extraordinary equitable reasons occurred that might excuse such late filing. See, e.g., *Iljazi v. Commissioner*, T.C. Summary Op. 2010-59 (client simply filed administrative claim for equitable innocent spouse relief beyond the time permitted in 26 C.F.R. § 1.6015-5(b)). But, on occasion, there have been good equitable reasons for the late filing. So, in recent years, the Clinic has argued before the courts for the equitable tolling of certain tax-related time limits. See, e.g., *Gormeley v. Commissioner*, T.C. Memo. 2009-252, appeal

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[1] Pursuant to Rule 37.3(a) of the Rules of this Court, the parties have consented to the filing of this brief. The letters granting consent are filed with the submission of this brief to the Clerk. This brief was not written, in whole or in part, by counsel for any party, and no person or entity other than Yeshiva University has made a monetary contribution to the preparation and submission of this brief. Yeshiva University, of which the Benjamin N. Cardozo School of Law and its Tax Clinic are components, employs counsel for *amicus*.

conceded by government (3d. Cir. 2010) (client sought equitable tolling of 90-day period at § 6015(e)(1)[2] in which to file Tax Court petition seeking equitable innocent spouse relief determination).

Besides representing its own clients, the Cardozo Tax Clinic has submitted amicus briefs to two Circuit Courts of Appeal arguing for equitable tolling. *Mannella v. Commissioner*, 631 F.3d 115 (3d Cir. 2011) (brief arguing for equitable tolling of time period in 26 C.F.R. § 1.6015-5(b) called "effective[]" and caused remand); *Terrell v. Commissioner*, 625 F.3d 254 (5th Cir. 2010) (brief arguing for equitable tolling of time period at § 6015(e)(1); issue not reached by court).

Counsel for the Clinic, its Director, has also published articles arguing for equitable tolling of several time periods contained in the Internal Revenue Code. Carlton M. Smith, "*Friedland*: Did the Tax Court Blow Its Whistleblower Jurisdiction?", 131 *Tax Notes* 843 (May 23, 2011) (arguing that the 30-day period at § 7623(b)(4) to file a Tax Court petition to review IRS' denial of a whistleblower award is subject to equitable tolling); Carlton M. Smith, "Equitably Tolling Innocent Spouse and Collection Due Process Periods", 126 *Tax Notes* 1106 (Mar. 1, 2010).

The Cardozo Tax Clinic does not represent any particular client in filing this brief. However,

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[2] Unless otherwise indicated, all section references are to the Internal Revenue Code, Title 26.

anticipating future clients who may want to argue for equitable tolling of certain Internal Revenue Code time limits, the Clinic is concerned that what this Court may say in this case in comparing the Medicare statute at issue herein to the statute at issue in *United States v. Brockamp*, 519 U.S. 347 (1997), may adversely affect future lower court opinions concerning jurisdiction and equitable tolling in the tax area.

SUMMARY OF ARGUMENT

The Medicare time period in dispute herein is not jurisdictional, and a regular *Irwin v. Dept. of Veterans Affairs*, 498 U.S. 89 (1990), presumption in favor of equitable tolling applies to the time limit – not a "weakened" version of the presumption. The government's argument that there is a "weakened" *Irwin* presumption in areas not known to be equitable, such as Medicare and tax collection, is not supported by logic or any authority. Since there is insufficient evidence to rebut the presumption herein, equitable tolling should be allowed of this case's time limit.

Contrary to this Court's statements in *Brockamp* and *Holland v. Florida*, 130 S. Ct. 2549 (2010), tax collection has historically involved equitable determinations – particularly where taxpayers and non-taxpayers seek to avoid the consequences of missing statutory deadlines. And, since *Brockamp* was decided in 1997, Congress has substantially increased the number of equitable tax collection determinations. To avoid accidentally, by dicta, effectively deciding lower-court disputes over

the possibility of equitably tolling Tax Code time limits other than section 6511, when resolving this Medicare time limit dispute, in its opinion herein, this Court should clearly indicate that it did not intend to suggest in *Brockamp* or *Holland* that no time deadlines in the Tax Code may be equitably tolled.

ARGUMENT

I. INTRODUCTION

This case involves a Medicare statute. It does not involve the Internal Revenue Code. However, from the briefing herein and the fact that the D.C. Circuit spent the last third of its opinion in this case discussing *Brockamp*, it seems likely that this Court, in its own opinion, will discuss what it said in *Brockamp* about why an Internal Revenue Code time period could not be equitably tolled. It would not be the first time this Court would discuss *Brockamp* in a non-tax case: In *Holland v. Florida, supra*, this Court also compared in detail a non-tax statute to the tax statute involved in *Brockamp*.

The Cardozo Tax Clinic is concerned both (1) about how language in *Brockamp* is being misused by the government in both tax and non-tax cases and (2) that this Court not, in this case, issue another gloss on the *Brockamp* opinion (like it did in *Holland*) that the government could misuse.

The Cardozo Tax Clinic does not see any error in the ruling of the D.C. Circuit below. Despite the complexity of the Medicare scheme in general, the 180-day time limit involved herein does not appear

to be jurisdictional. There is insufficient evidence that Congress wanted it to be jurisdictional. And this is a simple, short time limit as to which the *Irwin* presumption should apply. The statute should be subject to equitable tolling.

The respondent has effectively expanded upon the arguments summarized in the prior paragraph, so the Clinic has little to add on that score. Much of what the Clinic does have to add, though, are facts and arguments about how the opinion in this case may, if not carefully drawn, affect the interpretation of Internal Revenue Code time limits, as well. Accordingly, this brief proceeds in three parts:

The first part summarizes the Court's actual statements and holdings in *Brockamp* and *Holland*. It argues against the existence of something the government calls a "weakened" *Irwin* presumption in Medicare and tax cases.

The next part shows how one of the statements by this Court in *Brockamp* about equity in tax collection was, unfortunately, an overstatement when made, and, in light of later statutory developments, is even less accurate today.

The last part points out many tax deadlines for which the government has continued (with mixed success) arguing in the lower courts for no equitable tolling, citing *Brockamp*. These are disputes over time periods that may be affected by language in the forthcoming opinion in this case.

To avoid accidentally, by dicta, effectively deciding those and other Tax Code time limit disputes when resolving this Medicare time limit

dispute, the Cardozo Tax Clinic asks that this Court clearly indicate that it did not intend to suggest in *Brockamp* that no time deadlines in the Tax Code could ever be equitably tolled.

II. THERE IS NO SUCH THING AS THE GOVERNMENT'S "WEAKENED" *IRWIN* TOLLING PRESUMPTION

In the instant case, the government has argued that "even if [the *Irwin* presumption] . . . were to apply, any . . . presumption would be substantially weakened in this context, where equitable principles do not traditionally govern the substantive law and where Congress enacted a time deadline eighteen years before this Court's decision in *Irwin*." Pet. Br. 14. Further, the government has said that "Medicare Part A is far more analogous to the subject matter in *Brockamp* (tax collection) and *Beggerly* (land claims) than to the subject matter in *Holland* (habeas corpus) or *Irwin* (Title VII)." Pet. Br. at 45. The Cardozo Tax Clinic disagrees with much in these assertions.

Irwin was an employment discrimination suit. In it, this Court held that "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States." *Irwin*, *supra*, 498 U.S., at 95-96.

Brockamp involved two companion cases decided by the Ninth Circuit in 1995. In them, taxpayers made payments to the IRS before returns were due, yet subsequently failed to file returns on time. When late original returns were filed, they

showed overpayments. The taxpayers asked that the time periods to file timely refund claims be equitably tolled -- due to a taxpayer's mental incapacity in one case and alcoholism in the other. The tolling was sought for the periods that the taxpayers were effectively unable to act. Absent equitable tolling, the refund claims were untimely. Applying the *Irwin* presumption, however, the Ninth Circuit held that the time period in which to file a tax refund claim at § 6511(a) was subject to equitable tolling. *Brockamp v. United States*, 67 F. 3d 260 (9th Cir. 1995); *Scott v. United States*, 1995 U.S. App. LEXIS 37932 (9th Cir. 1995).

A dissenting judge in the Ninth Circuit thought otherwise. Among the reasons he gave for not finding the § 6511 period to be tollable was that "equitable tolling principles are inconsistent with the foundational underpinnings of the Internal Revenue Code. That is because tax laws are 'technical laws which are not subject to general principles of equity.' *Oropallo [v. United States]*, 994 F.2d [25] at 28 n. 3 [(1st Cir. 1993)] (citing *Lewyt Corp. v. Commissioner*, 349 U.S. 237, 249 (1955))." *Brockamp v. United States*, 67 F.3d at 265 (Fernandez, J., dissenting; some citations omitted).

In *Oropallo*, the First Circuit had called the requirement to timely file an administrative tax refund claim under § 6511 a jurisdictional requirement for a district court suit under 28 U.S.C. § 1346(a)(1). For this proposition, the First Circuit had cited this Court's holding in *United States v. Dalm*, 494 U.S. 596 (1990) -- decided just months before *Irwin*. *Oropallo*, 994 F.2d at 26. In part

because *Dalm* said that the § 6511 time period was jurisdictional, the First Circuit in *Oropallo* held that the time period was not subject to equitable tolling.

Lewyt Corp. -- cited by the First Circuit in *Oropallo* -- was a 1955 opinion of this Court deciding both the proper year for an accrual basis taxpayer to deduct excess profits taxes in computing income taxes and the proper amount of such deduction. In its opinion in *Lewyt*, this Court, preliminarily, noted "the rule that general equitable considerations do not control the measure of deductions or tax benefits". *Lewyt*, 349 U.S. at 240. The page from *Lewyt* cited in *Oropallo*, page 249, is actually one from the dissent. Page 249 contains the sentence, "Where the taxing measure is clear, of course, there is no place for loose conceptions about the 'equity of the statute.'" *Lewyt*, 349 U.S. at 249 (Frankfurter, J., dissenting). In any event, *Lewyt* involved assessment of the correct amount of tax -- not the subject matter of tax collection mechanisms (the subject matter of *Brockamp*).

In 1997, this Court reversed the Ninth Circuit's equitable tolling holdings in both of the companion cases in a combined opinion in *United States v. Brockamp*, 519 U.S. 347. This Court's *Brockamp* opinion was devoid of the words "jurisdiction" or "jurisdictional". Notably, the opinions in *Dalm*, *Brockamp*, and *Oropallo*, all predate this Court's recent statements that both this Court and lower courts have in the past called too many statutory requirements for suit – especially time limits – jurisdictional. See *Kontrick v. Ryan*, 540 U.S. 443, 454 (2004). Perhaps for this reason, in

his *amicus* brief herein, Professor Manning has not cited *Brockamp* as an example of a jurisdictional ruling of this Court.

In *Brockamp*, this Court held that § 6511(a)'s period in which to file a timely refund claim was not subject to equitable tolling. The Court wrote:

> Section 6511 sets forth its time limitations in unusually emphatic form. Ordinarily limitations statutes use fairly simple language, which one can often plausibly read as containing an implied "equitable tolling" exception. But § 6511 uses language that is not simple. It sets forth its limitations in a highly detailed technical manner, that, linguistically speaking, cannot easily be read as containing implicit exceptions. Moreover, § 6511 reiterates its limitations several times in several different ways. . . .
>
> To read an "equitable tolling" provision into these provisions, one would have to assume an implied exception for tolling virtually every time a number appears. To do so would work a kind of linguistic havoc. Moreover, such an interpretation would require tolling, not only procedural limitations, but also substantive limitations on the amount of recovery -- a kind of tolling for which we have found no direct precedent. Section 6511's detail, its technical language, the iteration of the limitations in both procedural and substantive forms, and the explicit listing of exceptions, taken together,

indicate to us that Congress did not intend courts to read other unmentioned, open-ended, "equitable" exceptions into the statute that it wrote. There are no counter-indications. Tax law, after all, is not normally characterized by case-specific exceptions reflecting individualized equities.

The nature of the underlying subject matter -- tax collection -- underscores the linguistic point. The IRS processes more than 200 million tax returns each year It issues more than 90 million refunds. See Dept. of Treasury, Internal Revenue Service, 1995 Data Book 8-9. To read an "equitable tolling" exception into § 6511 could create serious administrative problems by forcing the IRS to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for "equitable tolling" which, upon close inspection, might turn out to lack sufficient equitable justification. See H. R. Conf. Rep. No. 356, 69th Cong., 1st Sess., 41 (1926) (deleting provision excusing tax deficiencies in the estates of insane or deceased individuals because of difficulties involved in defining incompetence). The nature and potential magnitude of the administrative problem suggest that Congress decided to pay the price of occasional unfairness in individual cases (penalizing a taxpayer whose claim is unavoidably delayed) in order to maintain a more workable tax enforcement system. At the least it tells us that Congress would likely have wanted to

> decide explicitly whether, or just where and when, to expand the statute's limitations periods, rather than delegate to the courts a generalized power to do so wherever a court concludes that equity so requires.

Id., at 352-353 (citations omitted).

The sentence from *Brockamp* quoted above that states that "[t]ax law, after all, is not normally characterized by case-specific exceptions reflecting individualized equities"; *id.*, at 352; is not attributed to any prior opinion of this Court, but likely is a paraphrase of what Judge Fernandez said about tax law and equity in his dissent in the Ninth Circuit's opinion in *Brockamp*. It appears that the ultimate source for Judge Fernandez's statement was this Court's statement(s) in *Lewyt*, -- statement(s) in *Lewyt* (1) directed at computing the correct amount of a tax assessment, not its collection, and (2) when made therein not supported by citation to other opinions of this Court or to statutory provisions.

But, the next sentence from *Brockamp* did not refer to tax law generally, or to assessing the correct amount of tax, but to a subset of tax law, tax collection: "The nature of the underlying subject matter -- tax collection -- underscores the linguistic point." *Id.* This second sentence omits the qualifier "normally" used in the first sentence referring to "tax law" – suggesting to the reader that perhaps no aspect of tax collection involves equity in the Court's eyes. At least, this is how the government has, with one exception, read the combined effect of those two sentences ever since when the issue of possible

equitable tolling of a Tax Code time period has arisen.

In 2010, this Court decided *Holland v. Florida*, *supra*, in which it compared the statute there at issue to the one involved in *Brockamp*. *Holland* involved a provision of the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA) that limits state prisoners sentenced to the death penalty in filing for a writ of habeas corpus in the federal district courts. The AEDPA provides that a "1-year period of limitation shall apply to an application for a writ of habeas corpus by a person in custody pursuant to the judgment of a State court." 28 U.S.C. § 2244(d)(1). In *Holland*, an attorney missed the deadline to file a habeas corpus petition, despite repeated urging of his death-row client to file on time. Eventually, the client learned of the event that triggered the running of the period and filed a habeas petition himself, but it was five weeks late.

This Court held that equitable tolling could apply to the statute, stating:

> First, the AEDPA "statute of limitations defense . . . is not 'jurisdictional.'" It does not set forth "an inflexible rule requiring dismissal whenever" its "clock has run."
>
> We have previously made clear that a nonjurisdictional federal statute of limitations is normally subject to a "rebuttable presumption" in *favor* "of equitable tolling."
>
> In the case of AEDPA, the presumption's strength is reinforced by the

fact that "'equitable principles'" have traditionally "'governed'" the substantive law of habeas corpus, for we will "not construe a statute to displace courts' traditional equitable authority absent the 'clearest command'". The presumption's strength is yet further reinforced by the fact that Congress enacted AEDPA after this Court decided *Irwin* and therefore was likely aware that courts, when interpreting AEDPA's timing provisions, would apply the presumption.

Second, the statute here differs significantly from the statutes at issue in *United States v. Brockamp*, 519 U.S. 347 (1997), and *United States v. Beggerly*, 524 U.S. 38 (1998), two cases in which we held that *Irwin*'s presumption had been overcome. In *Brockamp,* we interpreted a statute of limitations that was silent on the question of equitable tolling as foreclosing application of that doctrine. But in doing so we emphasized that the statute at issue (1) "se[t] forth its time limitations in unusually emphatic form"; (2) used "highly detailed" and "technical" language "that, linguistically speaking, cannot easily be read as containing implicit exceptions"; (3) "reiterate[d] its limitations several times in several different ways"; (4) related to an "underlying subject matter," nationwide tax collection, with respect to which the practical consequences of permitting tolling would have been substantial; and (5) would, if tolled, "require tolling, not only procedural limitations, but

> also substantive limitations on the amount of recovery -- a kind of tolling for which we . . . found no direct precedent." And in *Beggerly* we held that *Irwin*'s presumption was overcome where (1) the 12-year statute of limitations at issue was "unusually generous" and (2) the underlying claim "deal[t] with ownership of land" and thereby implicated landowners' need to "know with certainty what their rights are, and the period during which those rights may be subject to challenge."
>
> By way of contrast, AEDPA's statute of limitations, unlike the statute at issue in *Brockamp,* does not contain language that is "unusually emphatic," nor does it "re-iterat[e]" its time limitation. Neither would application of equitable tolling here affect the "substance" of a petitioner's claim. Moreover, in contrast to the 12-year limitations period at issue in *Beggerly,* AEDPA's limitations period is not particularly long. And unlike the subject matters at issue in both *Brockamp* and *Beggerly* -- tax collection and land claims -- AEDPA's subject matter, habeas corpus, pertains to an area of the law where equity finds a comfortable home. In short, AEDPA's 1-year limit reads like an ordinary, run-of-the-mill statute of limitations.

Id., at 2560-2561 (citations omitted; emphasis in original).

Note how *Holland* seems to underscore the thought that there is no equity in tax collection,

stating that the subject matter at issue in *Brockamp* was "tax collection" and implying that, by contrast to the AEDPA, which pertains to habeas corpus, equity does not find a "comfortable home" in tax collection. There is no mention in *Holland* of *Brockamp*'s caveat that tax law is only "normally" not "characterized by case-specific exceptions reflecting individualized equities". 519 U.S. at 352. A flat rule seems implied by *Holland* for all tax collection statutes: They do not admit of equity. This is wrong, as will be detailed below.

Further, in the early part of the above *Holland* quote appear the words indicating that, if a time period is found in an equitable area, "the [*Irwin* tolling] presumption's strength is reinforced". The Court in *Holland* did not say that a time period existing in an area not known for equity is entitled only to a "weakened" *Irwin* presumption or no presumption at all.

In its opinion in this case, the D.C. Circuit, before analyzing the Medicare statute, spent a long paragraph summarizing the statements this Court made in *Brockamp* with respect to § 6511. Among the statements that the D.C. Circuit quoted was that "[t]ax law . . . is not normally characterized by case-specific exceptions reflecting individualized equities." *Auburn Regional Medical Center v. Sebelius*, 642 F.3d 1145, 1150 (D.C. Cir. 2011).

But, when comparing the Medicare statute herein to § 6511, the D.C. Circuit did not make any statement concerning whether the United States Code's Title 42 Medicare and Title 26 tax provisions were or were not areas as to which equity finds a

comfortable home. The issue of whether either area involved equitable determinations did not factor into the D.C. Circuit's decision in this case.

The Cardozo Tax Clinic believes the D.C. Circuit acted correctly in this regard. Under *Holland*, an *Irwin* presumption should be discussed as being "reinforced" only if (1) an area was traditionally thought to involve equity, (2) Congress, before *Irwin*, had engrafted an equitable provision into the United States Code in an area not previously considered equitable, or (3) after *Irwin*, Congress enacted a statute with a non-jurisdictional time period. The Medicare statue at issue herein satisfies none of those three criteria for producing a "reinforced" presumption.

The closest thing to discussing equity was the D.C. Circuit's response to the government's implicit argument about the comparative complexity of both Medicare and the Internal Revenue Code to other areas of the United States Code. The D.C. Circuit observed that:

> contrary to the Secretary's suggestions, the Court's focus in *Brockamp* was not the complexity of tax law per se, but rather the complexity of the provisions governing whether and when a claim could be filed. *Menominee*, 614 F.3d at 530 ("[F]ocus on the regulatory scheme as a whole is misplaced. The *Brockamp* Court did not concern itself with the complexity of the Tax Code as a whole, but the complexity of the time limitations found in § 6511."). It is true that as a general matter, the Medicare statute, like

> the Internal Revenue Code, is quite complex. But unlike the tax code, the Medicare statute does not create a detailed Jenga tower of deadlines and exceptions that equitable tolling might topple. Rather, its timing scheme is straightforward and readily amenable to tolling.

Id.

Irwin never said its tolling presumption was only appropriate in areas of the United States Code traditionally governed by equitable principles. The Title VII employment discrimination provision involved in *Irwin* was in part of Title 42 of the United States Code, 42 U.S.C. § 2000e-16(c). The Medicare provision involved in this case, 42 U.S.C. § 1395*oo*(a)(3), is also in part of Title 42. If the government's argument were accepted that the Medicare statute involved in this case – one drafted before *Irwin* and involving an area not traditionally equitable -- gets a "weakened" *Irwin* presumption of tolling, doesn't the statute involved in *Irwin* – also drafted before *Irwin* and not in an area traditionally equitable – also get a weakened *Irwin* presumption? How can *Irwin* itself involve a weakened presumption that it just laid out?

The truer reading of this Court's opinions in *Brockamp* and *Holland* must be that there is an *Irwin* presumption for all time limits in the United States Code that are not jurisdictional, and the *Irwin* presumption can only be "reinforced", not "weakened". There is no case law supporting the existence of a "weakened" *Irwin* presumption, and the government here cites none. Indeed, if there

were such a "weakened" presumption, most of the United States Code would likely fall into the government's "weakened" presumption. Surely, this is not what this Court intended to say when it laid down the *Irwin* presumption as a general rule for the entire United States Code.

Although the government has not made the argument in this case (a Medicare case), both before and after *Brockamp*, the government's position in every case where a taxpayer or other person has asked a court to equitably toll a time period in the Internal Revenue Code has been that either the time period is jurisdictional or, if not jurisdictional, is still not tollable. While the government has not always explicitly argued that there can never be equitable tolling in the Tax Code, that appears to be the thrust of its position.

As this Court decides the instant case and compares the statute herein to that in *Brockamp*, the Cardozo Tax Clinic asks the Court to be careful not to describe its *Brockamp* holding in a way that supports this government position. Rather, the Clinic believes that this Court should explicitly state that *Brockamp* was focused only on § 6511 and in no way should be read to preclude all other time periods in the Internal Revenue Code from being subject to tolling – i.e., that *Brockamp*'s language should not be read as turning the *Irwin* presumption in favor of tolling into an irrebuttable presumption against tolling in the Tax Code.

The Cardozo Tax Clinic is not setting up a straw man. As early as 1999, the government argued to the Seventh Circuit that *Brockamp*

precluded any time period in the Internal Revenue Code from being tolled. In *Flight Attendants Against UAL Offset v. Commissioner*, 165 F.3d 572 (7th Cir. 1999), the Seventh Circuit refused to decide whether a 90-day period to file a Tax Court declaratory judgment petition on pension plan qualification under § 7476 could be subject to equitable tolling because it saw no good reason for the petitioner having filed one day late therein. However, the Seventh Circuit expressed great skepticism of the government's argument that the specific period could not be tolled and that *Brockamp* prohibited the tolling of any time period in the Tax Code:

> The government asks us, on the authority of *Brockamp*, to broaden the exception to cover the entire tax code. But *Brockamp* is not broadly written. The Court pointed to emphatic statutory language not paralleled in the sections of the code at issue in this case indicating Congress's disinclination to permit any delays in the institution of tax refund litigation and to the administrative complexities that would ensue from injecting the complex, nuanced, case-by-case doctrine of equitable tolling into the assembly-line production of tax refunds in response to the enormous number of refund claims (more than a hundred million) filed every year.

Id., at 577.

To show how the government effectively continues to imply to the lower courts that no Tax Code time limit may ever be equitably tolled, below is a passage from motion papers filed earlier this

year by the government in a pro se individual's appeal to the Ninth Circuit of *Volpicelli v. United States*, 2011 U.S. Dist. LEXIS 140827 (D. Nev. 2011). *Volpicelli* involves whether the 9-month time period at § 6532(c) in which a nontaxpayer must file a district court wrongful levy action under § 7426 may be equitably tolled.

Logan Volpicelli was a minor in 2003, when the Reno police obtained a search warrant to look into the safe deposit box of his father, Ferrill. Ferrill has been incarcerated before. In the box, the police found two large checks from Ferrill's parents made out to Ferrill, and they turned the checks over to the IRS. The IRS applied the proceeds of the checks to Ferrill's tax debts. Within the 9-month time period at § 6532(c), Ferrill brought a wrongful levy suit in the district court for the District of Nevada on behalf of his son, arguing that the checks were intended to be gifts to Logan and that the checks had only been made out to Ferrill because Logan was a minor. In the Ninth Circuit, a parent cannot represent his minor child – a lawyer must – but Ferrill did not hire a lawyer (perhaps Ferrill lacked funds or was in jail). So, the court dismissed the case. In 2010, when Logan reached the age of majority (18), he promptly brought a new wrongful levy suit in the Nevada district court and asked the court to toll the § 6532(c) time period, citing *Supermail Cargo, Inc. v. United* States, 68 F.3d 1204 (9th Cir. 1995), in his papers. In *Supermail Cargo*, the Ninth Circuit, relying on the *Irwin* presumption, held that the § 6532(c) time period could be equitably tolled.

Supermail Cargo was decided before this Court issued its opinion in *Brockamp*. Perhaps because of this, the Nevada district court dismissed Logan's most recent suit, merely citing *Brockamp* and not even mentioning *Supermail Cargo*. In Logan's currently-pending pro se Ninth Circuit appeal, the Ninth Circuit had issued an order to show cause asking Logan to identify a substantial legal issue for his appeal.[3] In a responsive motion paper filed on March 12, 2012 in Ninth Circuit Docket No. 12-15029, the government wrote (page 9 n. 5):

> [T]he case law plainly supports the District Court's holding that, contrary to Logan's argument, the statute of limitations for a wrongful levy action cannot be equitably tolled. *United States v. Brockamp*, 519 U.S. 347, 354 (1997); *Becton Dickinson and Company v. Wolckenhauer*, 215 F.3d 340, 344-354 (3d Cir. 2000).

Becton Dickinson is a Third Circuit opinion that explains why the Third Circuit, relying on the alleged similarity between the purposes of §§ 6511 and 6532(c) and this Court's opinion in *Brockamp*, disagrees with the Ninth Circuit in *Supermail Cargo*. All one can make of the government's arguments in *Volpicelli* and in other recent cases is that any time a taxpayer – or even a nontaxpayer

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[3] The Ninth Circuit later decided that the case should go forward. The parties are in the midst of briefing the merits of the appeal. The government has not yet filed its merits brief.

like Logan -- asks[4] that a Tax Code time period be equitably tolled, the government cites *Brockamp* as enough of a refutation because it believes that there is no tolling in the Internal Revenue Code.

III. INDIVIDUAL EQUITABLE DETERMINATIONS OFTEN OCCUR IN THE AREA OF TAX COLLECTION

A. EQUITABLE TAX COLLECTION DETERMINATIONS WERE FAIRLY COMMON BEFORE *BROCKAMP*

This Court in *Brockamp*, unfortunately, overstated the situation when it said that "[t]ax law, after all, is not normally characterized by case-specific exceptions reflecting individualized equities". 519 U.S., at 352. This part of the brief focuses particularly on tax collection, not tax computation. As detailed below, there was a large amount of equity involved in tax collection prior to 1997:

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[4] In one instance, the IRS argued that a Tax Code provision was subject to equitable tolling, where the tolling would benefit the government. In *Doe v. United States*, 398 F.3d 686 (5th Cir. 2005), the government argued that the time period to assess taxes at § 6501 could be equitably tolled in the IRS' favor. The Fifth Circuit rejected the government's argument. This was not surprising, since § 6501 is nearly as detailed and exception-ridden as § 6511 and is essentially the flip side of § 6511. Indeed, an extension signed of the § 6501 assessment period also extends the § 6511 refund period. See §§ 6501(c)(4) and 6511(c).

1. Under the doctrine of "equitable recoupment" -- available in the district courts and the Court of Federal Claims prior to 1997 -- overpayments that are time-barred from refund under § 6511 can be applied to reduce timely-asserted tax assessments where the taxpayer would otherwise be taxed inconsistently on the same transaction. *United States v. Dalm*, *supra*; *Stone v. White*, 301 U.S. 532 (1937); *Bull v. United States*, 295 U.S. 247 (1935).

2. In *Enochs v. Williams Packing & Navigation Co.*, 370 U.S. 1 (1962), this Court recognized a similar judicial equitable exception – like that of equitable tolling -- to the Tax Code's anti-injunction act, § 7421(a). Section 7421(a) provides that, other than in the case of certain enumerated statutory exceptions, "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." In *Williams Packing*, this Court stated that despite the words of the act, "if it is clear that under no circumstances could the Government ultimately prevail, the central purpose of the Act is inapplicable and, under the [*Miller v. Standard*] *Nut Margarine* [*Co.*, 294 U.S. 498 (1932)] case, the attempted collection may be enjoined if equity jurisdiction otherwise exists." *Id.*, at 7.

3. In *United States v. Rodgers*, 461 U.S. 677 (1983), this Court considered whether § 7403

empowered a district court to order the sale of a family home owned by a delinquent taxpayer at the time he incurred his tax indebtedness, but in which the taxpayer's spouse (who did not owe any of that tax indebtedness) had a Texas "homestead" interest. This Court held that "district courts may exercise a degree of equitable discretion in § 7403 proceedings." *Id.*, at 709.

4. Section 6901(a) provides procedures for the government to assess and collect "liability, at law or *in equity*, of a transferee of property". (Emphasis added.) In *United States v. Bess*, 357 U.S. 51 (1958), this Court upheld a district court suit in equity against a widow -- enforcing the government's interest in the cash surrender value of a life insurance policy owned by the decedent husband at the time of his death.

5. In 1971, Congress enacted an "innocent spouse" provision at § 6013(e) to mandate relief from joint and several income tax liability in the case of certain large omissions of unreported income. Sec. 411, Pub. L. 98-369, 98 Stat. 790. The statute directed relief for an innocent spouse if a number of conditions were met, including that "taking into account all . . . facts and circumstances, it is *inequitable* to hold the other spouse liable for the deficiency in tax". Former § 6013(e)(1)(C) as originally adopted, before later amendment. (Emphasis added.)

6. In 1984, Congress amended the estimated tax penalty provision to provide for a waiver "with respect to any underpayment to the extent the Secretary determines that by reason of casualty, disaster, or other unusual circumstance the imposition of such addition to tax would be *against equity and good conscience*". § 6654(e)(3)(A). The Tax Court has granted the waiver in equitable cases of serious illness (AIDS) and/or mental disability. *Meyer v. Commissioner*, T.C. Memo. 2003-12; *Shaffer v. Commissioner*, T.C. Memo. 1994-618; *Carnahan v. Commissioner*, T.C. Memo. 1994-163.

7. The late-filing and late-payment penalties at paragraphs (1), (2), and (3) of § 6651(a) have long had "reasonable cause and not willful neglect" exceptions. This Court, in *United States v. Boyle*, 469 U.S. 241 (1985), indicated that these exceptions are likely met in equitable situations. In *Boyle*, this Court noted that the IRS, in most cases, did not impose the penalties when the circumstances that caused the taxpayer to pay late or file late were beyond the taxpayer's control. *Id.*, at 248 n. 6. Furthermore, this Court indicated that for disabled taxpayers, "disability alone could be an acceptable excuse for late filing." *Id.*, at n. 6. Even before 1997, the Tax Court had often granted these exceptions from the penalties in cases of mental disability -- consistent with the Court's comments in *Boyle*. *Shaffer v. Commissioner*, *supra*; *Carnahan v. Commissioner*, *supra*.

8. In 1986, Congress amended § 6404 by adding a subsection (e) that allowed the IRS to abate interest attributable to an error or delay of an IRS officer or employee in performing a "ministerial" act. Sec. 1563(a), Pub. L. 99-514, 100 Stat. 2762. Congress said it did "not intend that this provision be used routinely to avoid payment of interest." S. Rep. No. 313, 99th Cong., 2d Sess. 208 (1986). Rather, Congress intended the section to be used in instances in which an error or delay in performing a ministerial act resulted in the imposition of interest, and the failure to abate the interest "would be widely perceived as grossly unfair;" *id.* – i.e., where it would be perceived as inequitable. In 1996, Congress expanded the interest abatement authority to include an error or delay of an IRS officer or employee in performing a "managerial" act. Sec. 301(a)(2), Pub. L. 104-168, 110 Stat. 1457.

9. The IRS has had long-standing power to provide taxpayers with extensions to file their tax returns; see § 6081(a); and with extensions to meet election deadlines – deadlines that can be either in the area of tax collection or in the substantive calculation of the assessable amount of tax. One of the current regulations at 26 C.F.R. § 301.9100-1 *et seq.* governing requesting such so-called "9100 relief" lists acceptable excuses, including: "Failed to make the election because of intervening events beyond the taxpayer's control." 26 C.F.R. § 301.9100-3(b)(1)(ii). This sentence essentially

> acts as a blanket equitable exception. Moreover, the regulations even provide for certain automatic extensions that affect substantive tax liability -- including extending (1) the 15-month time limit in which to file an exemption application for a § 501(c)(3) organization under § 508, (2) the time limit in which to elect to be treated as a homeowners association under § 528, and (3) the time limit in which to elect to adjust basis on partnership transfers and distributions under § 754. 26 C.F.R. § 301.9100-2(a)(2).

In sum, even before this Court's 1997 *Brockamp* opinion, both through explicit Congressional authorization and judicial and regulatory exceptions, the collection and even imposition of taxes often involved equitable determinations.

B. EQUITABLE TAX COLLECTION DETERMINATIONS HAVE BECOME INCREASINGLY MORE COMMON SINCE *BROCKAMP*

Since 1997, Congress has increasingly called on the IRS to make equitable determinations in tax collection and liability matters. The Court should take this increasing amount of equity into consideration in any discussion of *Brockamp* in its opinion herein.

Further, in the listing of new equitable time limit provisions below, note that all were enacted after *Irwin*, so that, according to *Holland*, in the event these provisions are not held to present

jurisdictional time limits, they are all due a "reinforced" *Irwin* presumption.

1. In 1998, Congress implemented a statutory partial overruling of *Brockamp* by amending § 6511 to add a new subsection (h) providing that "the running of the periods specified in subsections (a), (b), and (c) shall be suspended during the period of such individual's life that such individual is financially disabled". Subsection (h) defines "financially disabled" as arising from a medically-determinable physical or mental impairment meeting certain requirements. Sec. 3202(a), Pub. L. 105-206, 112 Stat. 740-741.

2. Paired with the adoption of § 6511(h), in 1998, Congress repealed § 6013(e) and implemented a greatly-expanded "innocent spouse" provision at § 6015. Sec. 3201(a), Pub. L. 105-206, 112 Stat. 734-740. Section 6015(b) -- an expanded version of the former § 6013(e) -- retained the condition of the former § 6013(e) that, "taking into account all the facts and circumstances, it is inequitable to hold the other individual liable for the deficiency in tax". § 6015(b)(1)(D). Congress provided for even broader relief by adopting § 6015(f) -- applicable to both deficiencies in tax and underpayments of tax shown on the return. Subsection (f) provides that "if—(1) taking into account all the facts and circumstances, it is inequitable to hold the individual liable for any unpaid tax or any deficiency (or any portion of either); and (2) relief is not

available to such individual under subsection (b) or (c), the Secretary may relieve such individual of such liability." In 2005, the National Taxpayer Advocate reported to Congress that the IRS was receiving approximately 50,000 requests for relief under § 6015 a year. National Taxpayer Advocate 2005 Annual Report to Congress (Dec. 31, 2005) at 329, available at www.irs.gov. This is a significant amount of equitable tax collection determinations being made annually.

3. In the same 1998 legislation, Congress enacted new standards and procedures for offers-in-compromise ("OICs") under § 7122 by which taxpayers and the IRS can compromise assessed tax liabilities with finality. Sec. 3462, Pub. L. 105-206, 112 Stat. 764-767. Language in the Conference Committee Report encouraged the IRS to consider "factors such as *equity*, hardship and public policy where a compromise of an individual taxpayer's income tax liability would promote effective tax administration". H.R. Rep. No. 105-509 at 289 (1998) (emphasis added). The IRS later adopted regulations providing that, even when an individual taxpayer could pay his or her income taxes in full, "the IRS may compromise to promote effective tax administration where compelling public policy or *equity considerations* identified by the taxpayer provide a sufficient basis for compromising the liability. Compromise will be justified only where, due to exceptional

circumstances, collection of the full liability would undermine public confidence that the tax laws are being administered in a fair and *equitable* manner." 26 C.F.R. § 301.7122-1(b)(3)(ii) (emphasis added).

4. In the same 1998 legislation, Congress also created "Collection Due Process" ("CDP") hearings at the IRS Office of Appeals by enacting new §§ 6320 and 6330. Sec. 3401, Pub. L. 105-206, 112 Stat. 746-750. A taxpayer can now insist on a CDP hearing at either of two critical times in the tax collection process -- the issuance of a notice of intention to levy or the filing of a notice of federal tax lien. In a CDP hearing, the Appeals Officer must not only consider collection alternatives -- such as a proposed installment payment agreement under § 6659 or an OIC -- but also must consider "whether any proposed collection action balances the need for the efficient collection of taxes with the legitimate concern of the person that any collection action be no more intrusive than necessary". § 6330(c)(3). This is essentially an equitable inquiry. In the fiscal year ended September 30, 2011, the Office of Appeals held 51,832 CDP hearings. IRS Data Book, 2011 at 49 (Table 21), available at www.irs.gov. That is far more "equitable" tax collection hearings than there were Tax Court cases (29,442) and district court and Court of Federal Claims tax refund cases (397) closed, combined, in that year. *Id.*, at 61 (Table 27). Indeed, these last three additions to the Tax Code by the IRS

Restructuring and Reform Act of 1998 – by adding so many more equitable determinations to be administered by the IRS -- caused a prominent tax procedure professor to complain about the inefficiency of all these equitable determinations being thrust on the IRS, as follows:

> Congress made the wrong choice in creating these grounds [for equitable relief in innocent spouse, CDP, and OICs]. It forgot that costs as well as benefits must be considered. As said, the benefits were expected to be and apparently have been, for the rare cases. In securing those rare benefits, there were costs in many more cases: expended administrative resources that could have been applied to much greater effect elsewhere in the tax system. In short, the game was not worth the candle. At a time when the IRS is otherwise squeezed for resources, it is unwise, on balance, to expend its available resources on these residual, equitable categories.

Steve Johnson, "Symposium: Tax Compliance: Should Congress Reform the 1998 Reform Act: The 1998 Act and the Resources Link Between Tax Compliance and Tax Simplification", 51 *Kan. L. Rev.* 1013, 1059 (2003). The Cardozo Tax Clinic does not agree with Professor Johnson's conclusion, but does agree with him that the IRS is much

more in the equity-determining business since the 1998 legislation.

5. In a provision actually affecting the computation of assessable tax -- not tax collection -- in 2001, Congress amended the IRA provisions to allow the IRS to waive the 60-day window in which to roll over an IRA distribution "where the failure to waive such requirement would be *against equity or good conscience*, including casualty, disaster, or other events beyond the reasonable control of the individual subject to such requirement." § 408(d)(3)(I), added by sec. 644, Pub. L. 107-16, 115 Stat. 123 (emphasis added).

6. In 2006, Congress further expanded equity in tax collection when it resolved a Circuit split by amending § 6214(b) to provide that "the Tax Court may apply the doctrine of equitable recoupment to the same extent that it is available in civil tax cases before the district courts of the United States and the United States Court of Federal Claims." Sec. 858, Pub. L. 109-280, 120 Stat. 1020.

Furthermore, in addition to these new equitable provisions, Congress in 2006, added subsection (b) to § 7623, allowing the Tax Court (a court established as an Article I court under § 7441) for the first time to hear appeals of adverse IRS determinations concerning tax whistleblower awards. Although the tax whistleblower provision is not one that is inherently equitable, Congress may be happy to put a thumb on the scale of the whistleblower who for good equitable reasons misses

the simple, 30-day Tax Court filing time limit, just as this Court did for veterans – a traditionally favored class -- last year in *Henderson v. Shinseki*, 131 S. Ct. 1197 (2011) (holding that the period to file in an Article I veterans appeals court was not "jurisdictional").

As the Tax Code continues to grow, there are more and more instances in it where equitable factors are taken into consideration and more and more provisions that are not in the core of the tax collection provisions (such as the whistleblower provisions), such that equitable tolling of simple Tax Code time limits might be what Congress contemplates. The Court, thus, must take great care in its opinion in this case in making generalizations about the degree to which equity finds a comfortable home in the Tax Code.

IV. THE GOVERNMENT HAS IN MANY CASES BEEN READING *BROCKAMP* TO ESSENTIALLY ABOLISH THE *IRWIN* PRESUMPTION IN THE TAX CODE.

Why is the Cardozo Tax Clinic so worried about what this Court may say about the Tax Code when deciding this case? Well, there are many disputes currently ongoing in the lower courts over whether particular Internal Revenue Code time limits are jurisdictional or may be equitably tolled. To give a sense of the potentially-affected disputes, below is a partial listing of time periods in the Internal Revenue Code (other than § 6511) where taxpayers or non-taxpayers have argued for equitable tolling or that the period not be treated as

jurisdictional – together with citations of lower-court opinions addressing those disputes. While the courts have in most cases been reluctant to embrace tolling in the Tax Code, the argument has been accepted by some courts – even after *Brockamp*.

Further, the Tax Clinic notes that in *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385 (1982), among the reasons given by this Court for its holding that the time period -- currently located as 42 U.S.C. § 2000e-5(e) – in which to file with the EEOC a charge of employment discrimination was not jurisdictional, but was subject to equitable tolling, was that "a technical reading would be 'particularly inappropriate in a statutory scheme in which laymen, unassisted by trained lawyers, initiate the process.'" *Id.*, at 397 (internal citation for quote omitted). Among the arguments in this case made by the government is that "unlike the filing of charges under Title VII, the payment system under the Medicare program applies to sophisticated providers which are often assisted by 'trained lawyers'". Pet. Br. 34. Yet, many, if not most, of the people who have sought equitable tolling in the cases listed below -- like Mr. Volpicelli in his wrongful levy suit or "innocent spouses" filing an IRS Form 8857 seeking relief from joint and several income tax liability -- are self-represented. Thus, tolling might be appropriate at least in certain areas of the Tax Code where the self-represented predominate.

1. The at least two-year period in § 6532(a) in which to bring a tax refund lawsuit in district court or the Court of Federal Claims under 28 U.S.C. § 1346(a)(1). Compare *Marcinkowsky*

v. United States, 206 F.3d 1419, 1422 (Fed. Cir. 2000) (no tolling possible, citing this Court's statement in *Brockamp* that "tax law, after all, is not normally characterized by case-specific exceptions reflecting individualized equities"); *Webb v. United States*, 66 F.3d 691, 699 (4th Cir. 1995) (no tolling possible; noting the "limited relevance of equitable principles in tax cases"); with *Miller v. United States,* 500 F.2d 1007, 1010-1011 (2d Cir. 1974) (allowing equitable estoppel against the government with respect to the time limit).

2. The 9 month period in § 6532(c) in which to bring an action for wrongful levy in district court under § 7426. Compare *Becton Dickinson & Co. v. Wolckenhauer*, 215 F.3d 340, 344-354 (3d Cir. 2000) (no tolling possible, citing *Brockamp*); *Miller v. Tony & Susan Alamo Found.*, 134 F.3d 910 (8th Cir. 1998) (time period jurisdictional); *Dahn v. United States*, 127 F.3d 1249, 1252 (10th Cir. 1997) (time period jurisdictional); with *Supermail Cargo, Inc. v. United States*, 68 F.3d 1204 (9th Cir. 1995) (tolling possible, citing *Irwin*); *Gothenburg State Bank & Trust Co. v. United States*, 1999 U.S. Dist. LEXIS 7021 (D. Neb. 1999) (same, citing *Supermail Cargo*). See also *Volpicelli v. United States*, *supra* (district court in Nevada followed *Brockamp* and denied tolling; case is currently on appeal in Ninth Circuit).

3. The 90-day period in § 6015(e)(1) in which to bring in the Tax Court an action to determine innocent spouse relief from joint and several income tax liability. Compare *United States v. Pollock*, 2007 U.S. Dist. LEXIS 98153 (S.D. Fla. 2007) (tolling granted to pro se taxpayer to file late in Tax Court); with *Pollock v. Commissioner*, 132 T.C. 21 (2009) (Tax Court rejects late filing by the same taxpayer in the prior cited opinion because the Tax Court finds the time period jurisdictional). See also *Terrell v. Commissioner*, 625 F.3d 254, 258 n. 1 (5th Cir. 2010) (because IRS did not send notice to taxpayer's last known address, court noted, but did not reach, equitable tolling and equitable estoppel issues).

4. The 90-day time period in § 7476(b)(5) in which to file a Tax Court petition to review an IRS determination of the tax qualification of a retirement plan. *Calvert Anesthesia Associates v. Commissioner*, 110 T.C. 285 (1998) (time period jurisdictional); see also *Flight Attendants Against UAL Offset v. Commissioner*, 165 F.3d 572 (7th Cir. 1999) (court did not reach issue, but expressed skepticism that no tolling was possible).

5. The two-year deadline to file a Form 8857 requesting innocent spouse relief from income tax liability under 26 C.F.R. § 1.6015-5(b)(1) for equitable relief under § 6015(f). *Mannella v. Commissioner*, 631 F.3d 115, 126 (3d Cir. 2011) (remanding to Tax Court to consider possibility of tolling); *Hall v. Commissioner*,

135 T.C. 374 (2010) (regulatory time period invalid; six concurring judges would find period, if valid, subject to tolling – see Wells, J., concurring, at 387 n. 5). The IRS subsequently abandoned enforcing the regulatory deadline. Notice 2011-70, 2011-2 C.B. 135.

6. The 30-day period in § 7623(b)(4) in which a whistleblower may seek Tax Court review of an award. *Friedland v. Commissioner*, T.C. Memo 2011-90 (rejecting equitable estoppel argument).

7. The 60-day period in which a notice partner may file a petition for readjustment of partnership items under § 6226(b)(1). *A.I.M. Controls, L.L.C. v. Commissioner*, 672 F.3d 390 (5th Cir. 2012) (distinguishing *Henderson v. Shinseki*, 131 S. Ct. 1197 (2011), rejecting tolling, and finding period jurisdictional).

With these, and no doubt more, Tax Code time periods arguably subject to tolling, this Court, again, must exercise considerable care in drafting the opinion herein not to, by dicta, cause all lower courts to automatically hold that Tax Code time deadline may never be equitably tolled.

CONCLUSION

This Court should find that the Medicare time period in dispute herein is not jurisdictional and that a regular *Irwin* presumption in favor of equitable tolling applies to the time limit – not a "weakened" version of the presumption. Since there is insufficient evidence to rebut the presumption herein, equitable tolling should be allowed of the time limit involved in this case. To avoid accidentally, by dicta, effectively deciding lower-court disputes over the possible equitable tolling of Tax Code time limits other than those in § 6511, when resolving this Medicare time limit dispute, in its opinion herein, this Court should clearly indicate that it did not intend to suggest in *Brockamp* or *Holland* that no time deadlines in the Tax Code could ever be equitably tolled.

October 18, 2012

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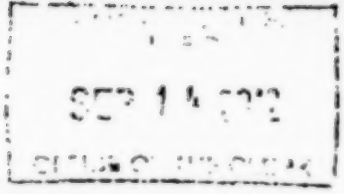
AMICUS CURIAE BRIEF

RECORD
AND
BRIEFS



No. 11-1231

IN THE
Supreme Court of the United States

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the District of Columbia Circuit

BRIEF FOR PROFESSOR SCOTT DODSON AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

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INTEREST OF *AMICUS CURIAE*

I am a professor at the University of California, Hastings College of the Law, where I teach and write in the areas of federal jurisdiction and procedure. My institutional affiliation is provided for identification purposes only. I have an interest in the clarification of the boundaries, scope, and regulatability of federal jurisdiction, and in the continuing vitality and stability of jurisdictional doctrine. On that basis, I submit this brief in support of neither party.[1]

SUMMARY OF ARGUMENT

In recent years, this Court has taken an interest in what is properly typed "jurisdictional." A series of opinions has clarified jurisdictional doctrine in helpful and productive ways.

This case, however, presents a question that, whatever its answer, need not implicate jurisdictional doctrine. The question can and should be answered through independent assessments of statutory construction, common-law traditions, and administrative policy. The question should *not* be answered by resort to jurisdictional classifications.

Jurisdictional classifications will not dispose of this case. Nonjurisdictional deadlines may disallow equitable tolling. Contrapositively, jurisdictional deadlines may allow equitable tolling. In short,

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[1] I notified counsel of record for both parties and the Court-appointed *amicus* on August 28, 2012, of my intention to file this brief. Their written letters of consent are attached. No counsel or party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus* and his academic institution made a monetary contribution to its preparation or submission.

whether a statutory deadline is jurisdictional does not resolve whether it is subject to equitable tolling.

For this reason, the Court should answer the important question presented without deciding the jurisdictional character of § 1395*oo*(a)(3).

ARGUMENT

THE COURT SHOULD DECIDE THIS CASE WITHOUT RESOLVING THE JUISDICTIONAL CHARACTER OF § 1395*oo*(a)(3).

At times, this Court has taken a jurisdiction-first approach of deciding the jurisdictional character of a judicial limit to define its effects. That approach assumes that jurisdiction has immutable characteristics: It is not subject to principles of equity, discretion, estoppel, forfeiture, consent, or waiver; courts must police its boundaries sua sponte; and a jurisdictional defect may be raised and decided at any time prior to final judgment. *See Ins. Corp. of Ir. v. Compagnie des Bauxites de Guinée*, 456 U.S. 694, 702 (1982). The approach also assumes that a nonjurisdictional rule has (at least presumptively) the inverse effects of jurisdiction. *See, e.g.*, *Day v. McDonough*, 547 U.S. 198, 205 (2006) ("A statute of limitations defense . . . is not 'jurisdictional,' hence courts are under no *obligation* to raise the time bar sua sponte.") (original emphasis); *id.* at 213 (Scalia, J., dissenting) (stating that ordinary time-bar defenses "are nonjurisdictional and thus subject to waiver and forfeiture").

Some of this Court's opinions, relying on these assumptions, have followed this jurisdiction-first approach. In *Bowles v. Russell*, 551 U.S. 205 (2007), for example, the Court determined that the deadline

to file a notice of appeal in a civil case is jurisdictional and therefore not subject to equitable exceptions for noncompliance. *Id.* at 213. The Court engaged no separate analysis of the appellate deadline's effects; it merely held the deadline to be jurisdictional and assumed, therefore, that the normal effects of jurisdictionality followed.

In other cases, however, the Court has taken an effects-based approach that avoids the jurisdictional-characterization decision and instead construes the effects of the limit directly. For example, in *Hallstrom v. Tillamook County*, 493 U.S. 20 (1989), the Court was presented with the question of whether the 60-day notice requirement of the Resource Conservation and Recovery Act was a limit on federal subject-matter jurisdiction. However, the Court declined to answer that question and instead answered the narrow question presented by the facts: whether the requirement was amenable to equitable exceptions. *Id.* at 31. The Court answered that question directly without addressing the jurisdictional character of the notice requirement.

The Court has followed this effects-based approach in recent cases. For example, the petition for certiorari in *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130 (2008), phrased the question presented as whether the Tucker Act's six-year limitations period was jurisdictional. The precise issue in that case, however, was whether a court must enforce the limitations period even if the United States, as a party-defendant, had waived the issue. The Court rephrased the question presented to reflect these terms and answered yes. In the process, this Court avoided characterizing the limitations period

as jurisdictional or nonjurisdictional. *Id.* at 135 (characterizing the time bar as a "more absolute" bar that justifies departure from usual waiver rules).

In this case, the effects-based approach of *Hallstrom* is better than the jurisdiction-first approach of *Bowles*. Cases like *Bowles*, which resolve the broader jurisdictional characterization, decide both more and less than needed. That is because the assumptions underlying the jurisdiction-first approach are flawed. In truth, the jurisdictional characterization of a limit does not inexorably define its effects.

This truth is easier to appreciate with nonjurisdictional rules. Nonjurisdictional rules can have jurisdictional effects. *See* Scott Dodson, *Mandatory Rules*, 61 STAN. L. REV. 1, 6 (2008). And they often do. *See, e.g.*, *Day*, 547 U.S. at 206-07 (a habeas petitioner's procedural default may be raised sua sponte); 28 U.S.C. § 2254(b)(3) (the habeas exhaustion requirement cannot be forfeited by the State); *Jones v. Block*, 549 U.S. 199, 201 (2007) (the PLRA's exhaustion requirement is mandatory); *cf. Kontrick v. Ryan*, 540 U.S. 443, 457 n.12 (2004) (certain bankruptcy rules may not be circumvented by consent of the parties). The point is that nonjurisdictional rules do not have a defined set of effects. Thus, a characterization of the 180-day limit in § 1395*oo*(a)(3) as nonjurisdictional will not resolve whether it is amenable to equitable tolling.

Although somewhat harder to appreciate, the flip side is true as well: jurisdictional questions can have nonjurisdictional effects, in myriad ways. *See* Scott Dodson, *Hybridizing Jurisdiction*, 99 CALIF. L. REV. 1437 (2011). For example, although the deadline to

file a civil notice of appeal is jurisdictional, the statutory framework specifically directs courts to apply the deadline with certain equitable considerations in mind. 28 U.S.C. § 2107(c) (allowing a district court to extend the deadline for "excusable neglect or good cause"). The boundary set by the appellate deadline may be jurisdictional, but that boundary can be influenced by statutorily mandated considerations of equity.

Could other considerations not expressed in the statute's text affect a jurisdictional limit? Those who read statutes according to expressed textual terms may say no; those who think statutory law can incorporate implicit considerations may say yes. *Cf. Teague v. Regional Comm'r of Customs*, 394 U.S. 977, 981 (1969) (Black, J., dissenting from denial of certiorari) (construing the jurisdictional deadline for filing a civil petition for certiorari as incorporating flexibility for "certain extenuating circumstances"). The point is that "things may depend upon one's preferred method of statutory interpretation, but they ought not depend upon the jurisdictional nature of the statute." Dodson, *Hybridizing*, at 1461.

For these reasons, this Court should eschew jurisdictional labels and adhere to the *Hallstrom* effects-based approach instead of the *Bowles* jurisdiction-first approach. An effects-based approach would allow a direct and narrow resolution of the question presented: whether the time limit in § 1395*oo*(a)(3) is subject to equitable tolling. It also would allow resolution without calling into doubt the Secretary's "good cause" exception to the deadline, a construction that is not directly implicated by the facts of this case.

CONCLUSION

This Court should answer the question presented without resort to jurisdictional characterizations.

Respectfully submitted,

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September 14, 2012

AMICUS CURIAE BRIEF

No. 11-1231

In The
Supreme Court of the United States

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES.

Petitioner.

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The District Of Columbia Circuit

BRIEF OF QUALITY REIMBURSEMENT SERVICES, INC., AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether the 180 day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. §1395oo(a)(3), is subject to equitable tolling.

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INTEREST OF *AMICUS CURIAE*

Quality Reimbursement Services (QRS) is a large healthcare consulting organization with offices throughout the United States.[1] QRS has extensive experience in assisting hospitals with respect to analyzing the various components of the Medicare Disproportionate Share (DSH) payment adjustment. QRS represents a significant number of hospitals in appeals before the Provider Reimbursement Review Board (PRRB) in cases involving the DSH payment adjustment, as well as other aspects of Medicare reimbursement. QRS is currently assisting several hospitals in connection with numerous equitable tolling appeals now pending before the PRRB. The Court's decision in this case will likely be dispositive as to the outcome of these appeals.

SUMMARY OF ARGUMENT

I. The Secretary's regulations authorizing an extension of the 180 day appeal period are arbitrary and capricious. These regulations impose an absolute bar against extending the time period for filing appeals more than three years after the determination of the

[1] No counsel for a party authored any part of this brief, and no person other than *amicus* or its counsel made any financial or other material contribution to fund the preparation or submission of this brief. Both petitioner and respondents have furnished their written consent to the filing of this brief.

fiscal intermediary. These regulations are therefore inconsistent with generally established equitable tolling principles, which require that the appropriate tolling period be determined on a case by case basis.

II. The duties and obligations of a Medicare provider are set forth in an agreement with the Secretary mandated by § 1866 of the Social Security Act, 42 U.S.C. § 1395cc. This contract stipulates that the provider will perform certain services in accordance with statutes and regulations, and in return will be eligible to receive reimbursement from the Secretary for those services.

Prior to the establishment of the PRRB, the former U.S. Court of Claims had jurisdiction under the Tucker Act, 28 U.S.C. § 1491, over provider reimbursement disputes arising under the Medicare Act. The basis for this jurisdiction was the section of the Tucker Act authorizing the U.S. Court of Claims to adjudicate contract disputes between private parties and the U.S. government. Accordingly, Auburn's claims in this case are analogous to claims sounding in contract, which is an area familiar to private litigation. This further supports the availability of equitable tolling to the case at bar.

III. The Centers for Medicare and Medicaid Services (CMS) has a fiduciary obligation with respect to its administration of the Federal Hospital Insurance Trust Fund. Medicare disproportionate share (DSH) payments are made for the benefit of hospital, as opposed to Medicare beneficiaries. Therefore, the

Secretary's fiduciary obligation to disclose payment errors extended to the hospitals in this case. The Secretary's failure to disclose these errors deprived the hospitals of an opportunity to appeal within the 180 day period prescribed by statute. Allowing equitable tolling would be consistent with the intent of Congress in imposing fiduciary disclosure obligations upon the Secretary.

ARGUMENT

I. The Regulation Authorizing the Board to Extend the 180 Day Filing Deadline Cannot Withstand Scrutiny under the Arbitrary and Capricious Standard of Review

Pursuant to 42 U.S.C. § 1395oo(a)(3), hospitals may appeal a final determination of its fiscal intermediary (often referred to as an "NPR") to the Provider Reimbursement Review Board ("PRRB") within 180 days after receipt of the NPR. The Secretary's regulations further provide for a "good cause" extension to the 180 day requirement. 42 C.F.R. § 405.1836. An extension may be granted only if the provider demonstrates that "it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control." 42 C.F.R. § 405.1836(b). These regulations prohibit the Board from hearing any appeal filed more than three (3) years after issuance of the NPR, regardless of the circumstances of the individual case. 42 C.F.R. § 405.1836(c)(2). The Secretary's regulations further provide that a decision

by the PRRB that the provider did not demonstrate good cause for requesting an extension is not subject to judicial review. 42 C.F.R. § 405.1836(e)(4).

The Secretary concedes that the provisions of 42 C.F.R. § 405.1836, which authorizes the PRRB to extend the 180 day filing deadline, is subject to review under an arbitrary and capricious standard. Pet. Br. at 16-17; 29-31. This regulation cannot withstand scrutiny under this standard, even assuming that its promulgation was within the scope of the Secretary's regulatory authority.

The hallmark of review under the arbitrary and capricious standard is reasoned decision-making. This requires the agency to articulate a satisfactory explanation for its action, including a "rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 77 L. Ed. 2d 443, 103 S. Ct. 2856 (1983) (quoting *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962)). In reviewing the agency's explanation, a court must "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* See also *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416, 28 L. Ed. 2d 136, 91 S. Ct. 814 (1971).

The regulation permitting the Board to extend the 180 day filing deadline is not technically an equitable tolling provision. This regulation permits the PRRB to accept appeals "after the applicable 180 day

time limit" has expired. 42 C.F.R. § 405.1836(a). On the other hand, equitable tolling does not *extend* the 180 day period, but rather *stops* the running of the 180 day clock. *Harper v. Ercole*, 648 F.3d 132, 139-140 (2d Cir. 2011).

Nonetheless, the normative principles governing equitable tolling are at least by analogy applicable to the Secretary's regulations. The Secretary's regulations are utterly inconsistent with these principles.

As a general rule, a party is entitled to equitable tolling by demonstrating that "(1) that he has been pursuing his rights diligently, and (2) that some extraordinary circumstance stood in his way." *Pace v. DiGuglielmo*, 544 U.S. 408, 418, 125 S. Ct. 1807, 161 L. Ed. 2d 669 (2005). The decision as to whether equitable tolling applies must be made "on a case-by-case basis." *Holland v. Florida*, 130 S. Ct. 2549, 2563, 177 L. Ed. 2d 130 (2010). Accordingly, the court must be guided by "awareness of the fact that specific circumstances, often hard to predict in advance, could warrant special treatment in an appropriate case." *Id.* at 2563. As noted in *Holland*, courts must be cognizant of "the need for flexibility" and "for avoiding mechanical rules" in deciding whether equitable tolling should be applied. *Id.* at 2563 (internal quotations omitted).

The Secretary's regulations eschew a flexible approach in favor of rigid and absolute prohibitions. These regulations provide that an appeal filed more than three years after the fiscal intermediary's

determination is prohibited under any and all circumstances. 42 C.F.R. § 405.1836(c)(2). The imposition of such fixed and rigid deadlines is not consistent with well established principles of equitable tolling.

In her preamble to the 2008 revisions, the Secretary stated that the three year limit was justified because it is a sufficient period of time "to recover from the unseen event and gather the necessary records, and make the necessary preparations for filing an appeal." 73 Fed. Reg. 30190, 30206, May 23, 2008. However, the amount of time required to recover from the extraordinary circumstances which prevented timely filing will inevitably vary from case to case. *Holland*, 130 S. Ct. at 2563. As recognized in *Holland*, it is not possible to fix an outer limit to the equitable tolling period.

The regulation at 42 C.F.R. § 405.1836 is not consistent with the Secretary's stated purpose of providing sufficient time for providers to file their appeals when "extraordinary circumstances" occur. *Id.* at § 405.1836(b). This case demonstrates that providers may be deprived of the information required to assert their appeals for a considerably longer period than three years. The Secretary's refusal to acknowledge this possibility by arbitrarily concluding that three years will always be an adequate time period for the provider to recover from any delay reflects an arbitrary and capricious conclusion on the part of the agency. *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962).

II. Claims under the Medicare Act Are Analogous To Contract Claims

The availability of equitable tolling may depend upon whether the claims asserted against the government are analogous to those which arise in the context of litigation between private parties. *Chung v. United States DOJ*, 333 F.3d 273, 277 (D.C. Cir. 2003). The Court of Appeals correctly held that Auburn's claims for additional provider reimbursement under the Medicare Act were analogous to actions sounding in contract. *Auburn Reg'l Med. Ctr. v. Sebelius*, 642 F.3d 1145, 1149, fn. 1 (D.C. Cir. 2011).

Health care facilities must sign a detailed contract with the Secretary if they choose to participate in the Medicare program. This agreement is commonly referred to as the "provider agreement." The contents of the provider agreement are established by § 1866 of the Social Security Act, 42 U.S.C. § 1395cc. This agreement imposes detailed obligations upon providers in connection with the provision of services to Medicare beneficiaries. In exchange, the provider is eligible for payment for these services as computed in accordance with the provisions of the Medicare Act. 42 U.S.C. § 1395cc(a)(1).

Participation in the Medicare program on the part of providers is voluntary. *Queen City Home Health Care Co. v. Sullivan*, 978 F.2d 236, 247 (6th Cir. 1992). Like other federal contractors, Medicare providers voluntarily agree to perform services in the manner required by their agreements with the

government in exchange for payment. See e.g., *In re University Medical Center*, 973 F.2d 1065, 1076-1077 (3d Cir. 1992) (Medicare provider agreements are executory contracts, which like other government contracts are subject to assumption or rejection by a debtor under the Bankruptcy Code); *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130, 137 (D.C. Cir. 1982) (noting that the provider agreement is a contract between the provider and the Secretary); *Delta Health Group, Inc. v. United States HHS*, 459 F. Supp. 2d 1207, 1209 (N.D. Fla. 2006) ("The provider agreement, at bottom, acts as a contract with the federal government in which the provider agrees to furnish quality nursing services to Medicare beneficiaries in compliance with all the applicable federal and state regulations.").

Prior to the establishment of the PRRB in 1973, provider reimbursement disputes were adjudicated by the former United States Court of Claims, pursuant to its Tucker Act jurisdiction, i.e., 28 U.S.C. § 1491. *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 571 F.2d 328, 332 (5th Cir 1978); *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1077, fn. 46 (D.C. Cir. 1978). The Tucker Act provided that the Court of Claims (now the United States Court of Federal Claims) "shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States." 28 U.S.C. § 1491.

In *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct. Cl. 1976), a Medicare provider appealed the final determination of its fiscal intermediary denying a request for increased reimbursement. The Court of Claims held that it had jurisdiction under the Tucker Act to adjudicate the dispute "both because of plaintiff's contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers." *Id.* at 351; see also *Rio Hondo Memorial Hospital v. United States*, 689 F.2d 1025, 1028 (Ct. Cl. 1982).

Thus, until the advent of the PRRB, provider reimbursement claims under the Medicare Act were treated as contract claims against the United States. In *Bowen v. Massachusetts*, 487 U.S. 879, 108 S. Ct. 2722, 101 L. Ed. 2d 749 (1988), Justice Scalia in dissent suggested that the Court of Claims, and not the federal district courts, had jurisdiction under the Tucker Act over Medicaid reimbursement claims submitted by the State of Massachusetts. Justice Scalia stated as follows in this regard:

> *The Medicaid Act itself can be analogized to a unilateral offer for contract – offering to pay specified sums in return for the performance of specified services and inviting the States to accept the offer by performance.*

Bowen v. Massachusetts, 487 U.S. 879, 923 (1988).

As a result of the enactment of 42 U.S.C. § 1395oo, jurisdiction over provider reimbursement claims under the Medicare Act no longer lies under

the Tucker Act, but instead rests exclusively with the federal district courts. *St. Vincent's Medical Ctr. v. United States*, 32 F.3d 548, 549-550 (Fed. Cir. 1994). Nonetheless, Justice Scalia's offer to contract analogy in the Medicaid context is equally applicable to Medicare. The federal government invites health care providers to contract with the Secretary by entering into the provider contract specified by § 1866 of the Social Security Act, 42 U.S.C. § 1395cc.

The Secretary in this case breached the provider agreement by failing to pay hospitals in accordance with the statutory formula mandated by the Medicare Act. Accordingly, the Court of Appeals correctly applied the presumption of equitable tolling on the grounds that Auburn's request for additional Medicare reimbursement was analogous to a claim sounding in contract.

III. Equitable Tolling Should Be Permitted in this Case Based Upon the Government's Fiduciary Obligation to Disclose Underpayments to Providers

Auburn is seeking to recover disproportionate share funds resulting from inpatient hospitalization services rendered to program beneficiaries. 42 U.S.C. § 1395ww(d)(5)(F). With a few exceptions involving managed care, disproportionate share payments to hospitals are made through the Federal Hospital Insurance Trust Fund (hereinafter "Part A Trust Fund"). 42 U.S.C. § 1395i. The Part A Trust Fund

is itself financed through payroll contributions. 42 U.S.C. § 1395i(a).

At common law, a trust arises when three elements are present; i.e., a trustee, a beneficiary, and a trust corpus. *White Mt. Apache Tribe v. United States*, 249 F.3d 1364, 1373 (Fed. Cir. 2001). The Supreme Court has recognized that a heightened fiduciary responsibility is imposed upon the U.S. government when it acts as a trustee. *United States v. Mitchell*, 463 U.S. 206, 224-225, 103 S. Ct. 2961, 77 L. Ed. 2d 580 (1983).

The Part A Trust Fund is administered by trustees designated by statute to serve in that capacity. The Secretary of Health and Human Services, along with other high ranking government officials, is designated by statute as a trustee of the Part A Trust Fund. 42 U.S.C. § 1395i(b). The Secretary of Health and Human Services certifies to the Managing Trustee the payments which are required to be made under Medicare Part A. 42 U.S.C. § 1395i(h).

The Secretary, who serves on an ex officio basis, is not individually liable as a fiduciary of the trust fund. 42 U.S.C. § 1395i(b). However, this does not in any way diminish the fiduciary obligation of the U.S. Department of Health and Human Services to properly certify the amounts which are required to be paid from the Part A Trust Fund. 42 U.S.C. § 1395i(h). Indeed, the Centers for Medicare & Medicaid Services ("CMS") often refer in various public issuances to its fiduciary responsibility to make appropriate

payments from the trust fund. See e.g., 71 Fed. Reg. 27798, 27884, May 12, 2006 ("The mandate for implementing the Medicare program tasks CMS with fiduciary responsibilities that require us to develop an effective and efficient payment system. . . ."); 72 Fed. Reg. 47130, 47247, August 22, 2007 (noting the Secretary's "fiduciary responsibility to the Medicare trust fund to ensure that Medicare pays only for covered services."); 71 Fed. Reg. 47870, 47908, August 18, 2006 (CMS has "a fiduciary responsibility to administer the trust fund in order to provide quality care for our beneficiaries. . . .").

Generally speaking, the intended beneficiaries of the Medicare trust funds are individuals covered by the program, as opposed to hospitals. However, the present case is different, due to the unique purpose of the disproportionate share (DSH) payment adjustment.

The Medicare DSH adjustment was intended to compensate hospitals for the higher per case cost of treating all low income patients, including both Medicare and non-Medicare patients. See H.R. REP. No. 99-241(I) (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 594. Congress chose two proxies for measuring the low income patient population: (a) Medicare patients who are entitled to Supplemental Security Income (SSI), and (b) non-Medicare patients who are eligible for Medicaid. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I),(II); *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270, 272 (6th Cir. 1994).

Hospitals that qualify for the disproportionate share adjustment receive an increased payment amount for *every* Medicare patient discharge, *regardless of the financial resources of the patient on whose behalf the payment is made*. 42 U.S.C. § 1395ww(d)(5)(F)(ii). The reason is that the DSH adjustment is not intended for the benefit of the patient on whose behalf it is actually paid. Instead, the DSH adjustment is intended to compensate hospitals for their higher per case cost of treating all low income individuals, including both Medicare and non-Medicare patients.

Of course, the purpose of the DSH adjustment is not to benefit hospitals per se, but rather to subsidize their costs of treating low income individuals. Nonetheless, the DSH adjustment represents a unique situation in which a payment is made from the Part A Trust Fund that is not for the benefit of the program beneficiary on whose behalf it is made, but rather for hospitals who would otherwise be required to absorb the added cost of treating low income persons.

As such, CMS had a heightened responsibility to deal fairly with hospitals in connection with its administration of the DSH program. At common law, the duty to disclose is a core fiduciary obligation. *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 750-751. (D.C. Cir. 1990). In the present case, the Secretary was aware of material errors in her computation of the Medicare/SSI fraction of the DSH adjustment, but failed to disclose this information to the plaintiffs. See Complaint at ¶38.

The Secretary's duty to disclose these errors was heightened by the fact that she is solely responsible for the computation of the SSI fraction. 42 C.F.R. § 412.106(b)(2). The Secretary enjoys a monopoly of ownership over the data required to compute this fraction due to the government's refusal to release SSI entitlement data to hospitals. 70 Fed. Reg. 47278, 47440, August 12, 2005.

The circumstances of this case indicate that the government itself, either intentionally or inadvertently, was responsible for the hospitals' failure to timely file their claims. Congress created a trust fund and imposed fiduciary obligations upon the agencies responsible for administering that fund. This purpose would not be served if hospitals are precluded from filing their appeals solely as a result of the Secretary's actions in failing to disclose critical payment errors.

CONCLUSION

For the reasons stated herein, *amicus* Quality Reimbursement Services respectfully requests that this Court affirm the decision of the U.S. Court of

Appeals for the D.C. Circuit, and rule that the 180 day filing period specified in 42 U.S.C. § 1395oo(a)(3) is subject to equitable tolling.

Respectfully submitted,

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AMICUS CURIAE BRIEF

No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY
OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF OF SOUTHWEST CONSULTING ASSOCIATES, LP AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF OF SOUTHWEST CONSULTING ASSOCIATES, LP AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

STATEMENT OF INTEREST[1]

Southwest Consulting Associates, LP ("Southwest") is a healthcare consulting firm, founded in 1989 and managed and staffed by experienced accounting and information systems professionals as well as former hospital financial and operations executives.[2]

[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund the brief's preparation or submission. No one other than *amicus* or its counsel made a monetary contribution to the brief. Letters reflecting all parties' consent to this brief are on file with the Clerk.

[2] At its founding and for some of the years discussed in this brief, Southwest did business as Southwest Consulting Associates, Inc., which is now an affiliate of the limited partnership entity.

Southwest serves hospital clients in 41 states, and devotes its practice to assuring that these clients receive the reimbursement due them under the Medicare program each year (no more and no less), including particularly the correct amount of "DSH" payments[3] they are supposed to receive for serving a "disproportionate share" of poor patients.

Southwest's services include analysis of relevant public and hospital data that may bear on the client's Medicare reimbursement; preparation of the necessary reports for submission to the Secretary's agency ("CMS") and its Medicare Administrative Contractors (formerly known as "fiscal intermediaries"); monitoring of legislative, regulatory, and litigation developments in the Medicare and Medicaid reimbursement fields; and assistance with dispute resolution and litigation (both administrative and in federal court), in the event that the hospital is underpaid.

In its litigation role, Southwest has served as primary consultant on numerous "group appeals," whereby large groups of hospitals (sometimes aggregating hundred of hospitals and thousands of fiscal years) bring a common challenge to a particular agency policy, practice, or regulation which they believe has caused or will cause them to be underpaid their DSH reimbursement. Southwest has been involved in some of the most significant reimbursement litigation of the last decade, including advising the lead plaintiff and many other hospitals in consolidated cases that successfully challenged underpay-

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[3] For the sake of brevity and clarity, Southwest has tried to employ the same definitions and abbreviations that the parties have used, and has relied on the parties to inform the Court regarding the statutory components of the DSH calculation.

ments caused by CMS's treatment of Medicaid-eligible but unpaid patient days in its DSH calculation. *See In re Medicare Reimbursement Litigation*, 309 F. Supp. 2d 89 (D.D.C. 2004), *aff'd*, 414 F.3d 7 (D.C. Cir. 2005), *cert. denied*, 126 S. Ct. 1672 (2006). (The agency settled this litigation after the Court denied *certiorari*.)

The Secretary notes (Pet. Br. 9) that "[t]his [Auburn] case arises against the background of litigation brought by Baystate Medical Center." Southwest served as lead consultant to Baystate in that case, *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), and provided testimony to the agency's review Board (the Provider Reimbursement Review Board, or "Board") before the case proceeded to court. Southwest also has hundreds of clients who, like Respondent Auburn Regional Medical Center, wish to challenge the agency's SSI calculations more than 180 days after the relevant payment determinations (or "NPRs") were issued, and may rely on an equitable tolling theory to do so if the Court affirms in this case.

Southwest's interest as *amicus* is thus two-fold. First, Southwest is concerned that the parties' briefs do not and could not fully convey what actually happened in *Baystate*, focusing as they must on the legal and policy issues the Court has been asked to resolve. But the agency's troubling conduct in that case nonetheless is important to understand. It provides the factual grounding for Auburn's points about the need for equitable relief as a measured, appropriate, and much-needed check on a key public healthcare agency that often performs enormously important reimbursement calculations behind closed doors. Based on its direct involvement in *Baystate*

and the record in a similar case of agency misfeasance, *Cape Cod Hospital v. Sebelius*, 630 F.3d 203 (D.C. Cir. 2011), Southwest seeks to advance the Court's understanding of the type of conduct that forms the factual "background" of this dispute.

Second, Southwest has a strong interest in protecting the rights of its many clients in the regulated community, who are not before the Court now but whose right to the payments due them, now and in the future, may well be determined by what the Court decides here.

SUMMARY OF ARGUMENT

From the Secretary's description, one might get the impression that "the system worked" in *Baystate*, that the provider spotted mistakes in its DSH calculations soon enough to timely appeal them, and then was able to satisfy the agency's Board and a federal district court that the agency just came up a little short, making a few minor mistakes because of inevitable problems with complex data. *See* Pet. Br. 10.

According to the Secretary, nothing in that story should excuse "sophisticated" providers from the demands of an appeals process that has "functioned appropriately for almost four decades." *Id.* 23. If Baystate spotted the problem within 180 days, so the story goes, then other providers and their consultants should have, too, since there has been no finding thus far that the agency deliberately concealed anything. *Id.* 25-26; Cert. Petn. 27-28; Cert. Reply 9-10.

But that is a deeply revisionist story. The picture it paints of a well-functioning and well-intentioned administrative regime, never needing equitable

intervention by the judiciary, is belied by what actually happened in *Baystate* and at least one other recent, strikingly similar case called *Cape Cod*. Each involved recurring errors in a vital but fairly obscure calculation that the agency performs on its own, without any outside review. In each case, the errors cost hospitals billions in reimbursement for the services they provided to Medicare patients. They were camouflaged in each case by the agency's public misstatements, they persisted well past the point when the agency figured out what it was doing wrong, and they came to light only because someone at the agency let slip to a consultant just enough information to raise questions about what was really going on.

And even then, especially in *Baystate*, it took years of litigation and millions in legal fees to break through the Secretary's determined secrecy and confirm the outlines of her agency's mistakes for the broader community of providers, who otherwise would have had no reason to think they had been underpaid—and may not even today, thanks to measures the agency has since taken to mask the impact and obstruct provider inquiries. Indeed, as discussed more fully below, within months of losing *Baystate* at the district court level in 2008, the agency comprehensively revised its rules to limit testimony, discovery, and the scope of contested issues in its Board hearings, making it that much more difficult for anyone ever again to discover and prove agency error and misconduct.[4] The Secretary has also conveniently defined her agency as a non-

[4] The rules were proposed in June 2004, about a year after the first evidentiary hearing before the Board in *Baystate* and a few months before the second.

party to Board proceedings, among other things side-stepping her own regulation permitting prior payment determinations to be reopened and corrected when they were the result of "fraud or similar fault" pursuant to 42 C.F.R. 405.1885(d) (now 405.1885(b)(3)).

Particularly under circumstances like the ones presented in these two real-world "case studies," *Baystate* and *Cape Cod*, it is only basic justice to allow providers, at the very least, to make an argument to a court that equity should excuse them from strict compliance with the 180-day appeal deadline, especially given the Secretary's attempt to foreclose all other avenues to reviewing mistakes that her agency manages to keep out of the public eye.

ARGUMENT

I. CASE STUDY 1: *BAYSTATE* AND THE SSI FRACTION[5]

1. There are any number of areas in which Medicare reimbursement follows transparently from the data that the hospital itself either provides or can verify. Calculation of the Medicaid fraction is one example—the hospital knows how many patient days it had in a given year (the denominator) and can verify with the various state Medicaid agencies how many of those days were eligible for the DSH calculation (the numerator). In that type of situation, Southwest fully agrees with the Secretary: Barring some truly exceptional circumstances, no one should need more than 180 days from issuance of the NPR to figure out whether they have been underpaid.

But the Medicare/SSI fraction is another animal entirely, particularly its numerator. As the parties explain, the numerator requires a "match" of part A-entitled days against non-public SSI records that are maintained by the Social Security Administration and provided to CMS for it alone to perform the match and publish the resulting SSI fractions—with no input from the providers and, despite their re-

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[5] Unless otherwise indicated, these facts are drawn from the district court's unappealed decision in *Baystate*, 545 F. Supp. 2d 20, the Administrative Record ("AR") filed by the Secretary in that case (D.D.C. No. 06-1263), including the Board's March 17, 2006 decision ("Board Dec.," No. 2006-D20, also available on the CMS website) and Baystate's Statement of Material Facts as to which There Is No Genuine Dispute, filed in support of its motion for summary judgment [Dkt. No. 15]. *See Baystate*, 545 F. Supp. 2d at 25, 34 n.22 (noting that the Secretary "largely" did not dispute the errors and omissions found by her Board).

quest for it, no data given to them to verify the calculation. *See* Resp. Br. 11-12.

The Secretary's many references to "sophisticated providers" and their consultants miss the mark here, because no amount of sophistication and diligence would help to identify anything but possibly the most large-scale discrepancies in the agency's calculation. This is particularly so where, as here, the "false negatives" in the match were fairly small in percentage terms, though potentially very significant in dollar terms given the amount of reimbursement at stake for some hospitals, the huge size of the Medicare program, and the fact that no DSH whatsoever is available to hospitals who miss the qualifying threshold by even a hundredth of a percent. Moreover, the errors were repeated every year, making it impossible to detect them by looking for anomalies from one year to the next.

2. Then what explains *Baystate*? In large part, luck. In 1987, the year after the DSH adjustment was put in place, Congress enacted a special rule allowing multi-campus hospitals to have a separate DSH calculation performed for each campus. Applying that rule, CMS recalculated its prior "whole hospital" SSI fraction for a hospital called St. Joseph of Rhode Island, now performing a separate SSI calculation for each of St. Joseph's two campuses. But those separate campus recalculations did not add up to the agency's previous calculation for the hospital as a whole, as they should have, for the exact same time period. *See* AR1592. The problem was inexplicable, and it only got worse with later recalculation attempts. As a result, neither campus qualified for the DSH adjustment.

In 1993, St. Joseph hired Southwest to look into this issue. From April 1993 through June 1995, Southwest's David Pfeil had numerous discussions with CMS, including particularly Ann Tayloe, who was the key person at CMS responsible for DSH policy. Tayloe eventually told Pfeil that there must be some kind of problem with the SSI data. AR1591. Southwest urged CMS to revisit its processes and procedures for doing the SSI calculation, but made no apparent headway until March 1995, when Southwest informed CMS that it had advised St. Joseph to seek assistance from Senator John Chafee, who had sponsored the separate campus DSH calculation legislation. In April, CMS made St. Joseph a "one-time" offer that would qualify one of its two campuses for DSH for the 1989 fiscal year, and St. Joseph took that deal, without ever learning what the problem had been.

Two months later, in June 1995, CMS published a notice of proposed rulemaking, addressing the process for hospitals to request that CMS recalculate their SSI fraction for the hospitals' own fiscal year, as opposed to the federal fiscal year. CMS warned that SSI fractions "invariably" decreased whenever a hospital requested such a recalculation, suggesting that this was due to problems, not with the SSI data, but with *hospital data* concerning their numbers of Medicare patient days. 60 Fed. Reg. 29,202, 29,223-24 (June 2, 1995).

That explanation did not mesh with what CMS had told Southwest in the St. Joseph matter, and it was the more curious when the agency's fiscal intermediary revised St. Joseph's reimbursement decision for 1989 to implement the agency's one-time offer. That revision occurred in October 1995 without

reconsideration of the data submitted by the hospital, even though, four months earlier, CMS had put the blame on hospitals for problems with recalculations of their SSI fractions.

This was suspicious, an apparent effort to put hospitals off the track of whatever was going on, and it eventually led Southwest to advise Baystate to question the agency's SSI calculations. Baystate ultimately did that for fiscal years 1993-96. The hospital had already timely appealed various issues within 180 days of the NPRs for those years (issued in 1995-99, respectively), but, importantly, *not* the SSI calculation issue. Baystate added this issue to its appeals for all years much later, in November 1999 (*four years* after the fiscal 1993 NPR issued in 1995), under a regulation which at the time permitted the addition of new issues up until the hearing date so long as an appeal on some issues had been filed within 180 days (42 C.F.R. 405.1841(a)(1)). This liberty was sharply restricted after *Baystate*, as discussed more fully in part 7 below. At that time, moreover, there was nothing about the agency's published SSI percentages for Baystate that suggested any underpayment. Baystate was just taking an educated guess on the basis of a tip—informal, unspecific, and non-public remarks by agency personnel in another case which settled before the facts could be developed.

3. The story of what had happened within CMS would only emerge after ten days of testimony before the agency's Board in 2003 and 2004, mainly through cross-examination of the employees responsible for DSH calculation and policy at CMS, but also through retired SSA employees and representatives of Southwest.

As it turns out, CMS had known for a long time that there was a data problem with its calculation, and that it had nothing to do with the hospitals. In a 1995 deposition transcript that surfaced during the *Baystate* proceeding years later, the agency's designated witness, Tayloe, revealed that CMS got questions in 1991 from some California hospitals that thought their SSI fractions seemed low, but did not have the necessary understanding of the agency's calculation to raise any specific concerns. The questions nonetheless prompted agency personnel to visit SSA to see whether that agency's SSI data was accurate. AR943-59. Tayloe testified that, at the time, she saw no problem outside "the mind of the people inquiring," told the hospitals as much, and recalls no "further problems." AR958-59. Years later, however, one of her colleagues would testify in *Baystate* that CMS knew it had a problem with the numbers even *before* Southwest called about St. Joseph in 1993. Board Dec. 24 & n.120.

Thus, the agency had been concerned enough in 1991 to check on the data it was receiving from SSA, and, in April 1995, had settled St. Joseph rather than risk a Senator's questions about why patient days kept dropping out of the SSI fraction numerator. But when asked at deposition, the agency (through Tayloe) testified that the SSI data was "verified and correct," Board Dec. 33, and produced no documents—not even the recent settlement with St. Joseph—to comply with a Board order directing CMS to produce records relating to the accuracy, validity, and potential for error in its processes for determining hospitals' SSI percentages. *Id.* Instead, as mentioned, CMS issued a rulemaking notice blaming hospital data and then, when finalizing its

rule in September 1995, told the public that the SSI fraction calculation was performed by SSA, not CMS, and that CMS did not even have the SSI data. 60 Fed. Reg. 45,778, 45,811-12 (Sept. 1, 1995).

None of that was true. CMS had always done the "match," and the SSI tapes used to do it were stored under the desk of an agency programmer, as reflected in notes of an internal agency meeting on February 15, 1996. The same notes confirm CMS's understanding that the SSI tapes provided by SSA for the match "has always left off dead people." AR2113. In particular, as explained more fully during the *Baystate* proceedings, a patient who was alive and receiving SSI during his hospital stay during a given fiscal year might not be reflected as such in the SSI tape used for CMS's match because that tape is generated well after the close of the fiscal year, and would be routinely purged of records for patients who had died during their hospital stay or between their date of discharge and the date when SSA supplied its tapes to CMS.

Because of that peculiarity,[6] the patient would not produce a part A/SSI match for the SSI fraction numerator, even though he was entitled to both during his hospital stay and, naturally, the problem would only get worse (*i.e.*, more false negatives) as time went on, more people died, and more "stale" records were routinely purged. This, finally, was an explanation for St. Joseph: With every new recalculation of a given year, more people left the current

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[6] There was nothing inherently "wrong" with SSA's data. CMS simply failed to appreciate the substantial limitations of that data for CMS's purposes in performing the SSI/part A match.

SSI rolls, producing fewer and fewer matches for the prior year at issue.[7]

Initially, and to its credit, CMS set out to resolve the problem by requesting corrected tapes from SSA for prior years and then using them to run what was called a "Special MEDPAR Run for SSI Corrections," which would compare the number of SSI/part A days previously calculated against the number of matches that should have been counted had the corrected tapes been used. If the discrepancy was "material," the intent at that time was to recalculate prior SSI ratios accordingly. AR5254-55.

SSA provided the tapes promptly, and CMS had new match results ready by the May/June timeframe in 1996. At that time, a summary prepared by the agency showed that a significant number of Medicare hospital stays that previously had no SSI days associated with them now, upon recalculation, *did* have associated SSI days. The Board credited Southwest's estimate that, using this internal agency summary, and based on average figures for the

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[7] Although it does not acknowledge that CMS had already known about the problem for years, *Baystate*, 545 F. Supp. 2d at 27, this internal agency email (AR2111) succinctly describes the issue:

> RECALCULATION OF THE SSI PERCENTAGE FOR REQUESTING HOSPITALS PRODUCED RESULTS NOT CONSIDERED LOGICAL. AFTER ANALYSIS AND DISCUSSIONS WITH THE SSA PROGRAMMER (PAT CRIBBS), THE PROBLEM WAS IDENTIFIED. BENEFICIARIES THAT HAVE DIED AND IDENTIFIED AS 'stale' (ie. inactive after about a year) ARE NOT INCLUDED IN THE DATA THAT WE RECEIVE FROM SSA.

length of patient stays and the dollar value per SSI day, the aggregate impact on all hospitals could be about $4 billion for fiscal years 1989 through 1996.

In sum, CMS confirmed for itself that it had been significantly understating the SSI fraction numerator, thus underpaying DSH hospitals, and appeared ready to correct the problem. But then, for reasons CMS witnesses claimed not to recall, CMS staff received an unspecified "different direction" from the agency's "Policy" personnel, *i.e.*, Tayloe and her group. Board Dec. 34-35; AR 5254. No corrections were made. The corrected SSI tapes and the results of the CMS recalculation still existed as late as April 1997 (according to another email produced in *Baystate*), and they would have allowed every hospital to identify each patient stay and the precise number of days that were incorrectly omitted from CMS's prior calculations because of the omission of "stale" SSI records. But those key documents disappeared sometime later—including all the prior year tapes that a CMS programmer had been keeping under his desk—leaving just the summary document described above.

No one told the hospitals any of this, nor disabused them of the agency's false assertions that it did not have the SSI records, that it was not responsible for the SSI calculation, and that the SSI data was "verified and correct." Instead, CMS left standing the misimpression that any problems with subsequent recalculations were the hospitals' fault.

4. "Stale" records were by no means the only problem. In 1986, for example, the Secretary informed providers, in the Federal Register, that the agency would be using Social Security numbers to

perform the match of SSA's records against CMS's Medicare part A records, recognizing that this widely used identifier is unique to each patient. In fact, the agency never did any such thing, instead attempting to match something called a "HICAN" ("Health Insurance Claim Account Number") against SSA's "Title II" numbers, which are used, not for SSI, but to track benefits under the Social Security retirement program. That produced data mismatches that should not have occurred, and would not have occurred had CMS used SSNs as it led everyone to believe it was. The error must have dawned on the agency during the Board proceedings, because a year after he first testified that he had never used SSNs in the match, an agency witness tried to recant, telling a skeptical Board that CMS in fact did use SSNs as part of the match.[8]

This systemic error and several others are detailed in the district court's *Baystate* decision. What the district court had no occasion to address, however—and what may prove relevant to the equitable tolling question—is how those errors happened. According to the Congressional Budget Office's "March 2012 Medicare Baseline" (available on the CBO website), DSH now represents an $11 billion annual payment adjustment for all hospitals. Yet, as the Board found, the CMS's match process was devised "on the fly," based on a few phone calls and letters between CMS and SSA, without the testing or validation that usually accompanies a process of this

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[8] CMS implemented a change in 1996 that marginally improved the match by utilizing additional HICANs, but that change was made prospectively – no prior years were corrected, and providers were not told about the change or the reasons for it.

importance and potential complexity, and without any significant reassessment as the years passed. AR5054.

In sharp contrast, when the same two agencies got together to perform a very similar match to determine how much cash assistance SSA would pay out to SSI recipients who are in nursing homes, there were detailed discussions about the functional requirements of the match, there was testing and validation, and there was a determination to do the match using the individuals' own unique SSNs. Notably, and unlike DSH, more matches in this nursing home context actually reduces the government's expenditures, so there was every incentive to get it right. But with no one able to see inside its "black box," and no one but providers to bear the impact of an undercounting mistake in the SSI fraction numerator, CMS took a comparatively slapdash approach, and stayed with it even after problems came to the agency's notice.

5. Making matters worse, CMS went to disturbing lengths in *Baystate* to conceal the impact of all these mistakes. The Board issued subpoenas in 2000 that required CMS to produce specific data elements relating to each patient and patient day that was included in the SSI fractions for the fiscal years at issue. CMS did not comply, so Baystate brought a civil action in federal district court to compel a response for the 1995 fiscal year. The Secretary successfully moved to dismiss in 2001, submitting a declaration from a CMS employee to show that, after an "exhaustive search," the requested data could not be found. AR688.

About two years after that declaration, though, in a 2003 hearing before the Board, another agency employee revealed that the SSI and Medicare days data that CMS had used to compute the SSI fraction for the hospital's 1995 fiscal year were still in CMS's hands when the agency previously had declared otherwise under penalty of perjury. Not long before this revised testimony, the agency's counsel sent the witness an email, attaching a list of files he had located—responsive to the Board's subpoena—and asking whether the agency's prior federal court declaration was "*literal[l]y true (I hope)* in light of the files listed below." AR1631 (emphasis added).

CMS ultimately produced this data, but not before issuing an extraordinary warning to the Board that it "should proceed very cautiously with respect to any further discovery orders in this case." AR5791. The Board Chair responded by making clear that her Board had a responsibility to find the truth: "[I]n analyzing your client's caution that we tread very carefully here on other discovery orders from what I've seen it's very clear that we just need to get to the bottom of this and get the facts out," adding that "it became very clear after a lengthy examination" that "[y]ou had [responsive records] all along. It was right there." AR5799-5801, 5803.

By this time, the Board was deeply enmeshed in an unsuccessful effort to get its own agency to enforce the Board's subpoenas. In 2002, the Board issued a subpoena directing SSA to produce its SSI records for a sample of Medicare beneficiaries treated by Baystate in the relevant years. When SSA refused on privacy grounds, the Board asked the Secretary to enforce the subpoena in court pursuant to 42 U.S.C. § 205(e). The Secretary refused.

Baystate then went to its patients directly, and for a small population of still-living Medicare patients who consented to release of their SSI records, was able to confirm that some of these patients had not had their inpatient stays counted as SSI days in the CMS match. Armed with that proof, Baystate went back to the Board, which issued another subpoena in June 2003, directing SSA to produce its SSI records for all the hospital's Medicare patients in the years at issue, which the Board later said was "fundamental data that's needed to get the answers in this case." AR2617-18. When SSA furnished only part of that data (for deceased persons who had been patients in one of the years requested), the Board wrote directly to the Secretary, asking for assistance in getting the necessary information from SSA. *See* 42 U.S.C. 1395oo(i) (requiring Secretary to "make available to the Board such *** assistance as the Board may require to carry out its functions").

When that produced no results, either, in 2004, the Board made a formal request to HHS counsel for enforcement of its subpoenas. "There is no authority in the statute or regulations," the Board wrote, "for the CMS Administrator to block evidence from being sought or presented that the Board has determined is essential to a matter in dispute." AR6705. The CMS Deputy Administrator nonetheless refused to direct the agency's Office of General Counsel to enforce the Board's subpoenas.

While all this was going on, Baystate was looking for creative solutions. The hospital proposed to have SSA release its data to a CMS third-party contractor to verify—at Baystate's expense—which of the hospital's Medicare patients were entitled to SSI benefits during their inpatient stay. SSA ultimately

agreed to a version of this proposal, but CMS did not, telling Baystate that its Office of Information Services (headed by the employee who had signed the agency's declaration described above), was not willing to participate in Baystate's proposed alternative data match.

6. Ultimately, Baystate was able to prove to the Board that the agency's calculation of the SSI fraction was deeply flawed in several key respects that tended to deflate the fraction and underpay DSH hospitals, potentially by billions of dollars. But it took years of what amounted to trench warfare, at a cost to Southwest of $2.5 million by the time the Board issued its decision in 2006 (and with further review proceedings at the agency and in court still to come, bringing the total outlay to $3.9 million). Along the way, the hospital had the good fortune to find a former career SSA employee who was willing to speak openly about her interactions with CMS and the known limitations in the SSI records her agency provided; to have access to witnesses from Southwest who just happened to be in a position to glimpse the agency's mistakes years earlier; and an agency Board that was exceptionally persistent in demanding the truth from a recalcitrant agency and its witnesses.[9]

Virtually no providers, regardless of size or sophistication, would have had the resources and good

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[9] The Board admonished CMS's key DSH policy employee, Tayloe, for being "a bit disingenuous" in her testimony, Board Dec. 35 n.210, and asked her: "Are you saying you really, honest to God, don't remember any of this stuff?" AR5540. As the Board also noted, another CMS employee actually changed his testimony from one evidentiary hearing to the next, first testifying that he never used Social Security numbers for the match and then that he did. Board Dec. 16-18.

luck necessary to reach the truth of this situation even if they were given a decade to do it, let alone to take action within 180 days after the reimbursement determinations were issued for all the fiscal years that could be affected by these errors. The Board's 2006 decision in *Baystate* really was the earliest clue to the regulated community that they *might* have been underpaid as a result of flaws in CMS's calculation of the SSI fraction.

Even then, big questions remained, largely because the agency's many roadblocks and concealments in *Baystate* had succeeded in creating an evidentiary challenge that the Secretary made every effort to exploit—providers' inability to show the dollar impact of errors that the agency largely conceded. In the *Baystate* district court case, for example, in 2008, the Secretary's counsel initially met the court's questions on that point by saying "[w]ell, it depends what you mean by billions of dollars." Tr. 62 [Dkt. 68].[10]

Fortunately, Baystate had gotten enough of a peek behind the agency's curtain to make some educated guesses about impact and persuade the court that "the systemic monetary impacts of the agency's errors are potentially enormous," 545 F. Supp. 2d at 54 n.35, and eventually learned enough through post-judgment discussions with the agency to understand the extent to which the hospital had been underpaid in the years at issue. But *Baystate*

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[10] The agency's key policy employee similarly testified before the Board that, although she considers herself to be "a detail-oriented person," a DSH payment issue involving "a few hundred million dollars" would "[n]ot necessarily" have left a lasting impression on her, "given the amount of money involved." Board Dec. 35.

only required the agency to correct *that* hospital's SSI percentages for the years at issue in that lawsuit. It would have been impossible for most hospitals to similarly quantify the impact of this issue on them and, indeed, to the best of Southwest's knowledge, no hospital but Baystate with a pending appeal has either been paid for this issue or furnished the details necessary for them to determine whether and to what extent they were underpaid. This despite the fact that the Secretary successfully objected to district court supervision of the remand in *Baystate* on grounds that her agency well understood what needed to be done to fix the match process. Def. Partial Opp. to Pl. Mot. to Amend Opinion and Order, at 4-8 [Dkt. 44].

In fact, it took CMS until 2010 to announce its "fixes" for the errors identified in *Baystate,*[11] plus two more years to recalculate the SSI fractions it had already issued for 2006 and 2007 and issue first-time calculations for 2008 through 2010. This leaves prior years unaddressed and, even as to the later years that *were* addressed, leaves hospitals still in the dark about whether the numbers are right. That is because the agency released none of the underlying data necessary to verify the percentages and has confused the issue still further by not separating the *Baystate*-related impact from the impact of other controversial changes the agency implemented at the same time.[12]

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[11] *See* CMS Ruling No. CMS-1498-R (Apr. 28, 2010); 75 Fed. Reg. 50,042, 50,275-86 (Aug. 16, 2010).

[12] For example, CMS now includes another type of patient day in the same fraction (so-called "Medicare+Choice" days under part C) that had not been included when the calculation was first performed for 2006, thereby camouflaging the

7. In the more immediate aftermath of *Baystate*, the Secretary also took steps to minimize the chances that any other provider would be able to do what Baystate did at the Board level. In a final rule published on May 23, 2008, not quite two months after the district court decided *Baystate*, the Secretary amended her regulations governing Board appeals, effective August 21, 2008. 73 Fed. Reg. 30,190 (May 23, 2008). Providers would no longer be able to add appeal issues up until the date of hearing, as Baystate did, but would have only 60 days to do so beyond the 180-day appeal deadline. *Id.* at 30,202-03, 30,250. No discovery would be permitted any longer from the Secretary, CMS, or any federal agency, by subpoena or otherwise. *Id.* at 30,217-19, 30,257-59. In fact, the Secretary now made clear that her agency was not to be considered a "party" to the appeal at all, *id.* at 30,215, 30,256, even in cases where, as here, the entire dispute turns on a calculation that the agency itself performs using data that is not made available to the entities who *are* defined as "parties" (*i.e.*, the provider and the agency's fiscal intermediary). Among other impacts, that characterization brought into play HHS's "*Touhy*" regulations, which forbid agency employees from testifying or

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Baystate impact. And in the same agency ruling that announced the *Baystate* fixes, CMS-1498-R, CMS also required SSI fractions now to be calculated (or *re*-calculated for pre-2004 years not yet resolved on appeal) so as to treat so-called "dual-eligible exhausted benefit days" as days of Medicare part A entitlement for DSH purposes, thereby obscuring and potentially offsetting any DSH increase attributable to "fixing" the *Baystate* problems. Challenges to these policies have been and continue to be litigated. *See Northeast Hospital Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011); *Catholic Health Initiatives – Iowa Corp. v. Sebelius* (D.C. Cir. No. 12-5092); *Allina Health Servs. v. Sebelius* (D.D.C. No. 10-1463).

providing discovery in proceedings where the government is not a party, unless the head of the agency deems it in the agency's interest. *Id.* at 30,215, 30,256, 30,258; 45 C.F.R. §§ 2.3, 2.4.

Had those rules been in place before *Baystate*, CMS might still be miscalculating the SSI fraction in exactly the ways identified in that case. Even if Baystate had the time it needed to identify the potential underpayment and properly include it as an appeal issue, it would have been handicapped substantially at the hearing—no document discovery from CMS whatsoever and, most critically, no ability to call government witnesses and cross-examine them under oath. Having suffered through a case where it was undone by testimony from its own employees, the agency tried its best with these changes to make sure it would never happen again.

8. Here then, is a situation where CMS: concealed a truly massive set of mistakes; made affirmative misstatements (including under penalty of perjury) that put providers, the Board, and the courts off the track about what happened; still, to this day, has not fully disclosed the payment impact to hospitals; and has taken active steps to put the truth out of reach in future cases. Given those facts, it takes a certain amount of temerity to suggest, as the Secretary does, that there is no basis for any court in any case ever to consider equitable extension of the 180-day appeal period, and more, to tout the fact that neither the Board nor the district court in *Baystate* made a finding that the agency committed the sort of willful misconduct that often justifies equitable tolling in other contexts.

The reality is that, to prevail, Baystate only had to show that the agency acted arbitrarily and capriciously by failing to use the best available data to perform the relevant calculations. Had it been necessary to go further and prove fraud or similar fault on the agency's part, Southwest respectfully submits that this record would have been sufficient to do it. That thought evidently occurred to the Board Chair, who commented as follows on the agency's potential culpability (AR5800-01):

> As I say, I'm not *** trying to form an opinion on whether or not anything was done by the client, CMS, to willfully keep information out of the hands of the Provider and the Board or whether it was purely just a lack of understanding of who was doing what, but I do know that the government has been very keen in at least the last decade with regard to the Federal False Claims Act **** And as I recall, one of the standards of culpability in the False Claims Act is willful ignorance. And I think that's very reasonable and it should be imposed, but I also think that we to[o,] all of us that deal with federal health care funds should be held to the same standard. None of us should be excluded from that standard[.]

Moreover, if there has been no fraud finding (yet), one can also blame the Secretary's self-serving interpretation of a regulation, formerly 42 C.F.R. 405.1885(d), that was promulgated to extend the three-year limit for reopening reimbursement determinations if they were "procured by fraud or similar fault of any party to the determination." The Secretary now claims that her agency is not a "party" (echoing the post-*Baystate* changes to her agency's

hearing rules) and that, therefore, only fraud by *the provider* will excuse late reopening. Pet. Br. 7 n.5. As Auburn points out, Resp. Br. 10 n.4, 50 n.20, the agency said otherwise when the rule was first issued. (The district court in this case refused to credit the Secretary's revised view. Petn. 46a n.15.)

Having tried to make it impossible for providers to hold her agency accountable even for fraud, it is awkward to say the least for the Secretary to try to foreclose equitable tolling by arguing that no one yet has found that the agency engaged in the type of intentional dishonesty, deliberate indifference, or willful ignorance that most of us would call "fraud or similar fault."

II. CASE STUDY 2: *CAPE COD* AND THE "RURAL FLOOR"[13]

1. Most Medicare hospitals are paid based on a prospectively determined rate per discharge, which starts with a "standardized amount" that is periodically adjusted for inflation and other factors and then for the most part carried forward from year to year as adjusted, rather than recalculated from scratch. For each hospital, that standardized amount is multiplied by other factors that are calculated anew each year, including the "wage index," which reflects the difference between the average wage levels faced by each hospital in its local labor market versus the national average of hospital wages.

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[13] Unless otherwise indicated, these facts are drawn from the D.C. Circuit's opinion in *Cape Cod*, 630 F.3d 203, and the Administrative Record ("AR") and 2007 and 2008 rulemaking records ("R07" and "R08") filed by the Secretary in that case at the district court level (D.D.C No. 08-1751).

In 1997, Congress determined that the wage index was being applied in a manner that resulted in some urban hospitals being paid less than the average rural hospital in their state, and set out to correct that anomaly by enacting what is known as a "rural floor"—requiring that the wage index applied to an urban hospital be at least as great as the wage index assigned to rural hospitals in the same state.

Because this adjustment could tend to increase overall Medicare payments, however (by requiring upward adjustments to the wage indices for urban hospitals not otherwise offset by decreases elsewhere), Congress also required that the rural floor be made budget-neutral. That is, to the extent that the rural floor would increase aggregate Medicare payments as it altered the distribution of Medicare payments between urban and rural hospitals, those payments would have to be adjusted downward to offset that impact—to make sure Medicare paid no more in the aggregate to all hospitals nationwide than it would have without the rural floor. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4410, 42 U.S.C. 1395ww note. Rural floor is only one of several adjustments that require the agency to make a further adjustment to assure budget neutrality.

2. For years, the Secretary said in the Federal Register that she performed the budget neutrality adjustment in a "cumulative" manner. This meant that the aggregate payments resulting from applying the agency's published, rural-floor adjusted wage indices in one year would be compared to the projected aggregate payments resulting from the rural-floor-adjusted wage indices for the current year, and the budget neutrality adjustment would be applied

for the current year only to the extent necessary to address any *incremental* increase in aggregate payments versus the prior year that were attributable to the rural floor.

This incremental increase, if any, would be removed from the standardized amount to accomplish the budget neutrality adjustment, and the standardized amount, thus adjusted, would carry forward to the next year for possible further incremental adjustment. CMS's Federal Register notices that accompanied publication of its wage indices each year were not specific about the data variables the agency used in its calculation, but they did state explicitly that "budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior year] budget neutrality adjustments." *See, e.g.*, 71 Fed. Reg. 47,870, 48,147 (Aug. 18, 2006).

In 2006, however, a hospital consultant named Theodore Giovanis sent an email to the Deputy Director of CMS's Division of Acute Care, asking a number of technical questions about the agency's fiscal 2007 budget neutrality calculations that were not directed to the rural floor per se. The Deputy Director referred the questions to a staff member, who told Giovanis by email that the agency's practice was to compare projected aggregate payments in the current year *with* the rural floor applied against the prior year aggregate payments *without* any rural floor adjustment, and then use *that* difference to reduce the current year's standardized amount for budget neutrality purposes. AR58-60.

This was 180 degrees the opposite of what the Secretary had always told the regulated community.

Instead of adjusting each year for *incremental* gains attributable to the rural floor in that year only, recognizing that all prior year increments had already been captured in the standardized amount that the agency started with each year, CMS actually had been taking the combined budget impact of the rural floor for *all* years out of the standardized amount *each* year—which would mean, for example, that the rural floor budget neutrality adjustment for fiscal 2006 would reflect a fiscal 1998 incremental adjustment that was taken nine times, a 1999 adjustment taken eight times, and so on.[14]

Giovanis responded by email the same day, asking "[W]hy doesn't this [method] duplicate in some respect the carve out for the application of the floor[?]" AR59. The agency went silent. Giovanis then prepared timely formal comments on this issue for consideration by the agency as it was formulating its rules for fiscal 2007. The comments made very clear his concern that the agency had not used the so-called "cumulative" approach it had advertised, but instead an illogical formula that had a duplicative and compounding impact on the standardized amount, eroding it each year without any regard to what extent, or even whether, there was a rural floor impact anticipated for the coming year. *See* Giovanis Decl. (Pl. Mem. in Opp. to Def. Cross-Motion for Summ. J., Ex. 2 [Dkt. 30]).

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[14] "Specifically, the hospitals argue that CMS has duplicated prior adjustments by each year calculating the full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that incudes adjustments carried over from previous years." *Cape Cod*, 630 F.3d at 207.

Indeed, because the full running total of all prior budget neutrality adjustment was coming out of the standardized amount anew every year, without prior year reductions being put back into the standardized amount first to clean the slate, the standardized amount inevitably would decline every year even if there were no year-on-year changes in the rural floor impact. And without the clue provided by the agency's email, there would have been no way to tell that the Secretary was doing anything other than what she said she was doing, let alone that hospitals might be underpaid as a result.

Giovanis hand-delivered his comments, which were clearly marked as such, to an agency employee that he knew and had delivered materials to before. She, too, worked in the Division of Acute Care, reporting to the Deputy Director to whom Giovanis had sent his first email. Giovanis gave her three copies, one of them for the rulemaking record and one each, separately addressed, to the Deputy Director and the employee who had answered Giovanis' email. He would later swear out a declaration recounting all these facts.

But the agency's 2007 rules were issued without any acknowledgement of these comments, and just stated per usual that CMS would use the "same methodology" as in past years, then provided the same inaccurate explanation of that methodology as it had in those years. 71 Fed. Reg at 48,147. Advised by Giovanis, a number of hospitals brought suit challenging the agency's rules for 2007 and 2008. For the 2008 rulemaking, the Secretary acknowledged receiving comments directed to the "inappropriate duplicating effect" of her calculation, but she declined requests that she explain what had hap-

pened and neither admitted nor denied that the prior calculations were wrong. Instead, CMS changed its method going forward to a "non-cumulative" calculation (for unspecified reasons), and declined to do anything about pre-2007 errors or commenters' concern that these errors had by now been "permanently built into the standardized amount." 72 Fed. Reg. 24,680, 24,787 (May 3, 2007) (proposed rule); 72 Fed. Reg. 47,130, 47,330 (Aug. 22, 2007) (final rule).

In the *Cape Cod* litigation, which was eventually resolved by the D.C. Circuit in the hospitals' favor, the agency produced an administrative record for its 2007 rulemaking that omitted Giovanis' email and formal comments. The Secretary argued that the absence of Giovanis's comments indicated that they were not submitted or were not submitted properly, arguing that Giovanis had failed to call the phone number it had set up to arrange hand-delivery of comments to agency staff at CMS's Baltimore office.

The agency then submitted a declaration from the employee who had signed for the comments. She said she accepted packages from Giovanis perhaps 15 times, but did not remember this one, and "believe[s]" she would have refused the package if she had understood it contained public comments or if it required her to accept anything on behalf of the two other employees that Giovanis copied on his comments. Cerne Decl. (Reply Mem. in Supp. of Def. Cross-Motion for S.J., Ex. 1 [Dkt. 33]). This despite the fact that she had reviewed, corrected the date on, and then signed a delivery receipt labeled "Comment Letter to [CMS] on the Proposed FY 2007 IPPS Changes (CMS-1488-P) regarding 'Operating Payments Rates'—Budget Neutrality Adjustment."

Moreover, as the hospitals showed, the 2007 rulemaking record *did* contain several other comments that were either late or misaddressed and, most importantly, a partial copy of Giovanis's email exchange eventually showed up in the record for the *next* rulemaking year, 2008. R08:492-93. The agency neither admitted nor denied receiving the email or the comments, and furnished no explanation for how the emails could go missing in 2007 but wind up in the 2008 record, except to say that they "did play a role" in the change the agency made for 2008. Def. Mem. in Support of Cross-Motion for S.J. at 13 n.7 [Dkt. 26].

3. The D.C. Circuit invalidated the 2007 as well as 2008 rules, rejecting the Secretary's argument that the hospitals had waived their 2007 challenge when Giovanis failed to call the designated phone number. Ultimately, the errors he identified resulted in a reported multi-billion dollar settlement for thousands of hospitals for fiscal years going back to 1999. Chad Terhune, *Medicare to Settle Hospital Reimbursement Dispute,* Los Angeles Times (Apr. 12, 2012).

Here again, though, as with *Baystate*, it is not credible for the Secretary to make blithe assertions about a properly functioning system of administrative and judicial review, triggered by sophisticated, well-advised providers who had the time necessary to determine that they had been underpaid and act accordingly. Instead, as in *Baystate*, the agency in *Cape Cod* did an important calculation wrong from the beginning, but was insulated for years from any challenge. In both cases, the truth only came out later, and then only because of a rare, fortuitous lapse by someone at the agency, revealing a bit too

much to someone savvy enough to suspect the possible implications and, in that way, giving some providers the clue they needed to pursue the issue further—that is, *if* they proved to have the resources and persistence to litigate their way through the agency's wall of secrecy and denial. Most others in the regulated community just had to accept at face value the inaccurate things the agency had said publicly.

If that is truly the way the Secretary can be expected to operate, she should not be surprised when a provider such as Auburn argues that the equities—her agency's concealment—justify tolling the applicable review deadlines until the time when a reasonably diligent provider knows or should know that it has a solid basis to contest the agency's calculation of the Medicare payment due that provider.

CONCLUSION

Baystate and *Cape Cod* show that it can take years and the occasional breakthrough litigation outcome—potentially long after the Secretary's appeal and reopening deadlines expire for a given fiscal year determination—to reveal the serious errors that the agency has proven capable of making, particularly in the work that it performs behind closed doors. The availability of equitable tolling would provide modest assurance, in appropriate cases, that the time Medicare providers need to discover these mistakes does not automatically insulate the errors from review. Southwest therefore urges the Court to affirm the D.C. Circuit's decision.

Respectfully submitted,

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